NATIONAL PROJECT ON PREVENTING TORTURE IN INDIA

FROM PUBLIC AWARENESS TO STATE ACCOUNTABILITY

TAKE A PLEDGE AGAINST TORTURE

Resource Materials for Doctors, Psychiatrists & Psychologists

This project is funded by

European Union

Die Stiftung für liberale Politik
Friedrich Naumann Stiftung

A project implemented by

Peoples Watch

"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

Article 5, Universal Declaration of Human Rights (1948)

Resource Materials for

Doctors and Psychiatrists

Compiled by

Mr. Subhradipta Sarkar
Ms. Archana Sarma
(Law Researchers, People's Watch)

Edited by

Dr. K. Mathiharan M.D. (Forensic Medicine) **Ph.D**
Hon.Advisor, Institute of Legal Medicine, Chennai

Mr. Henri Tiphagne
(Lawyer & Executive Director, People's Watch)

Human Rights Intervention Series: 34

Resource Materials for Doctors and Psychiatrists

First Edition-October, 2006

Second Edition-December, 2007

Published by

People's Watch
6, Vallabhai Road, Chokkikulam,
Madurai-625002
Phone: + 91-452-2539520, 2531874
Fax: + 91-452-2531874
Email: info@pwtn.org
Website: www.pwtn.org

ACKNOWLEDGMENT

This volume is a compilation of resource materials for the National Awareness Training programs, a part of the EU-FNST-PWTN National Project on Preventing Torture in India: from Public Awareness to State Accountability", is meant for professionals including lawyers, criminal justice administrators, doctors, psychiatrists, teachers, civil society organizations, law enforcement officials, media, political parties etc. Valuable inputs have gone into the production of this volume from different sources. The publishers have acknowledged all those sources in the appropriate places of the volume. We are indebted to the individuals who gave their time and expertise in our accomplishment. We would like to acknowledge with appreciation and place on record the names of all those who have contributed in their different capacities.

We owe our special debt to Dr.Mathikaran, M.D. Ph.D, Institute of Legal Medicine, Chennai, Mr. Henri Tiphagne, Executive Director, People's Watch- Tamil Nadu (PW-TN) for undertaking the task of editing the entire work. We would like to express our gratitude to Mr.Subhradipta Sarkar and Ms. Archana Sarma, Law Researchers, PW-TN for the arduous task of compiling the materials.

Mr. S. Anand Kumar and Mr. N. Jeyaraman of the Computer Unit, PW-TN, undertook the mammoth task of alignment and designing. Mr. Jordan Fletcher, Fellow of the American India Foundation, extended his precious support in compiling the materials. Dr. K.Mathikaran and Mr.M.S.Giri, State Director of Andhra Pradesh (EU-FNST-PWTN National Project on Preventing Torture in India) both have provided us with valuable materials and constant support. Thanks are due as well to Ms. Sabine Nierhoff and Mr. David Green. It would not be an exaggeration to mention that the volume could not been completed without their hard work and enthusiasm.

We will be failing in our duty unless we offer our gratefulness to the interns, namely, Ms.Reena Arora, Mr. Arvind Kumar, Mr. Sherin Daniel, Kinaat Sisodia, Mr. Vinayak Mishra, Mr.Gaurav Shukla and Mr. Kishore Narayan for their contribution with their research documents which have been incorporated in this volume. We further wish to thank Ms.C.Gandhimathi, Ms. N. Mehari Nigar, Ms. J. Stella Maragathamani, Mr. S. Senthil Kumar and Mr.Karunanidhi of the Documentation Unit, PW-TN for extending their full co-operation.

In preparing this volume we took into consideration comments made by the State Coordinators and the State Directors of this Project. Last but not the least, we acknowledge all of them for their valuable suggestions.

People's Watch

People's Watch is a human rights organization which has been actively engaging itself in the protection and promotion of human rights in Tamil Nadu since 1995. Now, after ten years of work, the organization has expanded its concerns throughout the country.

People's Watch seeks to create a society free from human rights violations and discrimination. This vision finds its expression in two ways. First, People's Watch endeavors to hold the State accountable to its citizens for chronic abuses of their rights. Second, it attempts to spread a human rights culture which may be able to safeguard welfare and the freedom of all people.

Programs at People's Watch:

1) Building Monitoring and Intervention Capacity

People's Watch works to transfer skills and build the capacity of other groups in civil society. By creating human rights cells, individuals can play a significant role in defense of human rights. People's Watch hopes to identify and train more than ten thousand human rights monitors. These people will be drawn from different parts of Tamil Nadu and will represent diverse minorities, castes, backgrounds, religions, and political parties. They will learn to conduct fact-finding missions and document human rights violations, as well as to engage in local intervention and community-based rehabilitation. They will prepare various documents, including the Annual Report on Human Rights Violations, a compilation of violations such as custodial deaths, rapes and torture.

2) Human Rights Campaigns

People's Watch works to found a "Citizens for Human Rights Movement" (CHRM) that engages women and men from a broad spectrum of society's political parties, movements, castes, religions, trade unions, and civil society groups. The Movement will form taluk, district and state committees with male and female coordinators to protect and promote human rights throughout the state. People's Watch will work towards an independently functioning CHRM and sustain its ongoing effectiveness.

People's Watch has also been working to promote a Campaign Against Torture in Tamil Nadu. In addition to observing the International Day of Solidarity with Victims of Torture on June 26th, the Campaign plans to spread an anti-torture campaign to other states.

3) Rehabilitation Center for Torture Victims:

People's Watch operates two facilities that provide security and support to survivors of human rights violations. Located in Madurai and Mettur, the centers employ a holistic, rights-based approach to rehabilitation, involving individuals from diverse sectors of society in the recovery process. Centers provide psychological, medical, legal and social services to survivors and their family members, and through educational assistance and economic development projects, they promote the socio-economic rehabilitation communities affected

by torture. Finally, the centers encourage networking among survivors and between organizations and movements advocating for the rights of survivors.

4) The Institute for Human Rights Education

Following the tremendous success of its first Human Rights Education Initiative launched in Tamilnadu schools in 1997, People's Watch is now introducing Human Rights Education in schools across India. The plan targets eleven states for the next three years and envisions advocacy and lobbying efforts with the state and Central Governments. This project will coincide with the United Nations' World Program for Human Rights Education in Schools (2005 – 2008).

The Institute also produces training programs for government officials, teachers, students, and other members of the educational sector. As part of this process, People's Watch will publish human rights workbooks in Tamil, English and other local languages. People's Watch will also offer human rights intervention training programs to various strategic groups.

5) Communication: Documentation, Publication and Media

People's Watch uses every possible means to influence public opinion and foster public awareness of human rights. It documents and catalogues all violations of human rights in Tamil Nadu and maintains a library of human rights publications, fact-finding reports and other media for use by researchers and organizations. Additionally, People's Watch is creating a publishing house committed exclusively to human rights literature. Through its efforts, People's Watch hopes to create a culture of human rights across all segments of Indian society, thereby empowering all people to protect and promote the human rights of everyone.

6) Tsunami Relief Effort

Shortly after news of the tsunami's destruction was first broadcast to the world, People's Watch began contributing to the ongoing relief efforts. It provided direct assistance to over twenty thousand survivors in coastal communities and coordinated the many organizations eager to join the relief effort. People's Watch volunteers conducted two Rapid Impact Assessments in nine coastal districts. These sought to identify the most dire community needs, examine the long-term outlook on livelihoods, and assess provision of basic amenities such as water, sanitation, and healthcare facilities.

People's Watch played a significant leadership role in the formation of the Tsunami Relief and Rehabilitation Coordination for Tamil Nadu and Pondicherry (TRRC), a collaboration of many concerned organizations seeking to ensure that aid is delivered as quickly and effectively as possible within the State and Union. Additionally, and in collaboration with the SOCO Trust (Madurai) and Human Rights Law Network (Chennai), People's Watch (Madurai) created the Tsunami Legal Action Committee, which continues to fight for the legal rights of affected communities with respect to issues such as shelter, compensation, land, and insurance.

The National Project on Preventing Torture in India

European Union supported National Project on "Preventing Torture in India: from Public Awareness to State Accountability"

European Union has formally approved this national level project in the last week of December 2005 and it comes into effect from January 2006 for a period of three years. The aim of the action is to **initiate and model a national campaign for the prevention of torture in India**, with a deliberate focus on torture practices routinely employed by police. This project will be carried out in 10 States: Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, Rajasthan, Orissa, Uttar Pradesh, Madhya Pradesh, West Bengal, and Bihar.

The overall goal is **the prevention and reduction of torture in India**, where police abuses remain an entrenched and often routine law enforcement strategy. And its scope will include interventions against instances of assault and physical abuse, custodial death, custodial rape, threats and psychological humiliation, and deprivation of food, water, sleep, and medical attention.

Protect potential survivors of torture, particularly those belonging to vulnerable and marginalized communities,

- Highlight individual cases of torture as and when they occur,
- Improve institutional response to instances of torture by demanding state accountability,
- Advance an ethic of responsibility and restraint among law enforcement officers,
- Educate and enlist professional groups such as lawyers, social activists, doctors, psychiatrists, journalists, and teachers in the campaign to prevent and eliminate torture,
- Raise public awareness of torture as an unlawful and widespread abuse of police powers,
- Promote favourable policy outcomes in the form of anti-torture legislation and fulfilling of commitments to existing international treaties.

Two stages will drive the action's overall agenda: first, **the formation of ten state-wide networks to monitor instances of torture** and intervene on behalf of individual survivors ; and second, **a national awareness campaign** that uses this monitoring data to generate public and professional condemnation of torture practices within a wider culture of rights,

improve enforcement of and adherence to existing constitutional guarantees, and lobby for CAT ratification and stricter domestic laws in India's Parliament and the individual state legislative assemblies.

The **district-by-district torture monitoring** will be conducted by a corps of 100 torture monitors across the ten states, drawn from local affiliates coordinated by FNF's partner People's Watch. Torture monitors will investigate abuses as they occur in real-time—interviewing survivors , witnesses, and police, collecting documents, and mobilizing local media coverage. These fact-finding missions will subsequently provide the basis for **targeted legal interventions**, primarily in support of individuals from marginalized groups, performed by staff lawyers in each state.

The **national awareness campaign** coordinated by project staff will employ the raw data generated by these monitoring activities to drive media coverage, public education, and lobbying activities devoted to bringing greater visibility to the prevalence of torture in India. Reporting on individual instances of abuse will be matched by activities that aim to broadly educate public audience as to their rights and the legal resources available to them. On a policy level, the campaign will push to increase these protections. It will also include at its core a series of state-level awareness conferences targeting the various professions implicated in the elimination of torture: lawyers, social activists, doctors, psychiatrists, journalists, and teachers. Police themselves, as well as members of the judiciary, are also to be treated as **intermediaries**, receiving awareness training that addresses them as constructive partners rather than adversaries in this project.

We have established an office in each project state, headed by a state director, and assisted by a part-time lawyer and three program associates. In all fifty districts in which we work, one or two District Human Rights Monitors will engage in fact-finding missions and assist survivors of human rights abuses. In each state, civil society organizations in one taluk will undergo an intensive awareness program and serve as a model in uncovering best practices. This nationwide project is headed by a National Director, based in Madurai, Tamilnadu, and a National Program Officer, located in New Delhi.

TABLE OF CONTENTS

I. INTRODUCTION TO HUMAN RIGHTS

"The aim of all political association is the conservation of the natural and inalienable rights of man."

- Locke

1.1 What do we mean by 'Human Rights'?

'Human Rights' have been the subject of much jurisprudential discussion, which revolves around the idea of the entitlement of human beings to a range of legal rights, which are fundamental and inviolable in nature. Proponents of some types of natural law theory argue that, because man is made in the image of his Creator, he possesses an intrinsic dignity, which must be translated into legal rights.

'Human Rights' is both a simple as well as a difficult expression to define and comprehend. Simple in the sense that 'Human Rights' is defined simply as the rights of human beings. For example, D.D. Basu has defined 'Human Rights' as "those minimal rights, which every individual must have against the State or other public authority by virtue of his being a member of the human family, irrespective of any other consideration."[1] Gewirth described human rights as "rights which all persons equally have simply insofar as they are human." Difficult, in the sense, the way in which the expression 'Human Rights' is defined in the Protection of Human Rights Act, 1993.[2]

Before trying to understand the meaning of the expression 'Human Rights', it will be more appropriate to understand the meaning of the word 'Right' in its proper sense. Allen has defined 'Right' as "the legally guaranteed power to realize an interest."[3] Holland has defined 'Right' as "the capacity residing in one man of controlling, with the assent and assistance of the State, the actions of others."[4] Holmes has defined 'Right' as "nothing but permission to exercise certain natural powers and upon certain conditions to obtain protection, restitution, or compensation by the aid of public force."[5] Salmond defined 'Right' as "an interest which the law will recognize and protect, respect for which is a legal duty, disregard of which is a legal wrong."[6] All the above definitions of 'right' stress the recognition of the person's 'interest' or 'power' by the state/law. Therefore in view of the above definitions of 'right,' Human Rights will mean those interests of human beings, which are recognized and protected by the State.

However, there prevails another view, according to which 'Human Rights' are not dependent on the State. Jackson J. in **West Virginia State Board v. Barnette**[7] has observed, "the very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and to establish them as legal principles to be applied by the Courts. One's right to life, liberty and prosperity, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections."

1.2. Human Rights in India

In India, though much of the human rights are protected through Part III of the Constitution of India, there is no specific definition in the Constitution of India for 'Human Rights'. Only through the enactment of the Protection of Human Rights Act, 1993[8] the Parliament of India attempted to define 'Human Rights'. Section 2(d) of the Protection of Human Rights Act, 1993 defines 'Human Rights' as "the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants and enforceable by courts in India."

In India, **'Human rights' means rights relating to life, liberty, equality and dignity of the individual.** However, this is subject to a condition that these rights must be:

1. Guaranteed by the Constitution of India; or
2. Embodied in the International Covenants[9] (ICCPR and ICESCR, 1966) and enforceable by courts in India;

In view of the above, "Human rights" in India refers to:

- Rights relating to life;
- Rights relating to liberty;
- Rights relating to equality; and
- Rights relating to dignity of the Individual;

guaranteed by the Constitution of India or embodied in the International Covenants and enforceable by courts in India.

1.3. Rights guaranteed by the Constitution of India

Part III of the Constitution of India guarantees to persons certain rights called 'fundamental rights'. When human rights are guaranteed by a written Constitution, they are called 'Fundamental Rights' because a written Constitution is the fundamental law of a State.[10] The Constitution of India guarantees six fundamental rights. They are:

1. Right to Equality (Articles 14 to 18);
2. Right to freedoms (Articles 19 to 22);
3. Right against exploitation (Articles 23 & 24);
4. Right to freedom of religion (Articles 25 to 28);
5. Cultural and Educational Rights (Articles 29 & 30);
6. Right to Constitutional Remedies (Article 32)

Increasing awareness of human rights issues, and zeal of human rights activists, practitioners and judges, have contributed a lot in expounding the law on Human rights. The Supreme Court has adopted a very liberal and right approach in the interpretation of

fundamental rights as a result of which almost every human right recognized under the International Covenants has attained the status of fundamental right in India.

Notes:

[1] D.D. Basu, Human Rights in Constitutional Law, Wadhwa, Nagpur, 2003, p.8

[2] See Section 2(d)

[3] See L.B. Curzon, Jurisprudence, Cavendish Publishing Limited, London, 1993, p.222

[4] Id.

[5] Id.

[6] Ibid. p.229

[7] (1943) 319 U.S. 624 (638)

[8] Act No.10 of 1994

[9] See Section 2(f) for definition of "International Covenants."

[10] D.D. Basu, Human Rights in Constitutional Law, Wadhwa, Nagpur, 2003, p.2

1.4. Components of human rights in India

Over a period of time, the right to life, liberty, equality and dignity pertaining a human being has been given a lot of new dimension through legislations and interpretation of law by the higher courts, i.e. the Supreme Court and the High Courts in the country. They have been expanded to encompass numerous other rights within its fold. Following are an enumeration of those rights in India.

a) Rights relating to life

The right to life includes the following rights:

1. Right to live with human dignity
2. Right to basic necessities of life
3. Right to Privacy
4. Right to Shelter
5. Right to Access to Road
6. Right to Tradition, Culture and Heritage
7. Right to Livelihood
8. Right to Food, Clothing and Shelter
9. Right to Free Legal Aid
10. Right to a Speedy Trial
11. Right to Know
12. Right against delayed execution of death sentence
13. Right of a Person not to be subjected to 'Bonded Labour'

14. Right to Medical Aid
15. Right of women to be treated with decency and proper dignity
16. Right to health and medical care of workers
17. Right to Health
18. Right to healthy environment
19. Right to education
20. Right to a decent burial
21. Right to Food

b) Rights relating to liberty

This right includes the following rights:

1. Right to Travel Abroad
2. Right to socialize with members of one's family and friends
3. Right to write a book
4. Right to a Speedy Trial
5. Right to legal aid
6. Right to privacy
7. Right against solitary confinement
8. Right against bar fetters
9. Right against handcuffing
10. Right against custodial violence
11. Right to Freedom of Speech and Expression
12. Right to Receive Information
13. Freedom of the Press
14. Right to participate in picketing or demonstration
15. Right against Telephone Tapping
16. Right to assemble peacefully
17. Right to form associations or unions
18. Right to freedom of movement
19. Right to reside and settle in any part of India
20. Right to acquire, hold and dispose property
21. Right to Freedom of Trade and Occupation

22. Right against Ex-Post-Facto Law
23. Right against Double Jeopardy
24. Right against Self-incrimination
25. Right to be informed about the grounds of Arrest
26. Right to have someone informed of arrest or detention
27. Right to consult and to be defended by a lawyer
28. Right of arrestee to be produced before the nearest magistrate within 24 hours of arrest
29. Right against exploitation
30. Right of a citizen of India not to be compelled to work without wages
31. Right against exploitation of children
32. Freedom of Religion and conscience
33. Freedom to profess or practice religion
34. Freedom to manage religious affairs
35. Right to establish and maintain institutions for religious and charitable purposes
36. Right to manage its own affairs in matters of religion
37. Right to acquire and administer property
38. Freedom as to payment of taxes for promotion of any particular religion
39. Right to conserve language, script or culture
40. Right of minorities to establish and administer educational institutions

c) Rights Relating to Equality

This right implies Equality before law and Equal protection of the laws. Hence, reasonable classification is allowed. But it is not antithetic to arbitrariness. Natural justice is an integral part of guarantee of equality. Though there is prohibition of discrimination but protective discrimination is allowed while making special provisions for women, children, in favour of socially and educationally Backward Classes of Citizens or for the Scheduled Castes and the Scheduled Tribes. It speaks in terms of:

1. Equality of opportunity in public employment,
2. Right to equal pay for equal work
3. Right against practice of untouchability
4. Abolition of titles

d) Rights relating to Dignity of the Individual

The right of a individual to live with dignity comprises of the following components:

1. Right to live with human dignity
2. Right of workmen to lead life with dignity
3. State to provide minimum conditions ensuring human dignity
4. Right of women to be treated with decency and proper dignity
5. Rape is violative of Right to Dignity
6. Sexual Harassment at Work Place is violative of Right to Dignity
7. Right of prostitutes to live a life of dignity
8. State's duty to provide means to citizens to live a life of dignity
9. Right to Reputation
10. Right to Dignity of foreigners
11. Right to Dignity – not to be ignored in Prisons
12. Torture or cruel, inhuman or degrading treatment would be offensive to human dignity
13. Polluted Environment offends Right to Dignity

SOURCE: Largely borrowed from **S. Shantha Kumar, *Human Rights*, People's Watch-Tamil Nadu, Madurai Nov, 2005,** with modifications.

II. GENERAL ASPECTS OF TORTURE

2.1 Introduction

In order to conduct effective documentation and investigation of torture, it is necessary to have an understanding of the meaning of torture, its prohibition, the definitions in international law, and the legal implications of its use. The object of this chapter is to provide an overview of the prohibition, explain the key elements that are found in torture and other ill-treatment, and to give guidance on how to recognize unlawful treatment. Rather than being a technical and detailed description of all legal aspects, this chapter is written for non-lawyers and aims to supply the basic foundations of knowledge needed by all those who come into contact with torture and its victims, with special attention given to health professionals. The chapter also contains information about the types of situations in which allegations of torture might arise, and sets out the aims and objectives which documentation and investigation hope to achieve.

2.2 What is torture?

2.2 (a) The prohibition in international law

The prohibition of torture in international law is notable in that it is absolute, applying at all times and in all circumstances. Article 5 of the 1948 Universal Declaration of Human Rights states: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.' The right to be free from torture and other ill-treatment is taken up in major international and regional human rights treaties, including the International Covenant on Civil and Political Rights (1966), the European Convention on Human Rights (1950), the American Convention on Human Rights (1978) and the African Charter on Human and People's Rights (1981). In 1984 the UN adopted the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, highlighting the particular attention given to this absolute prohibition, and providing additional rules to assist in prevention and investigation.

The prohibition of torture is the concern not only of those countries which have ratified particular treaties, but is also a rule of general or customary international law, which binds all states even in the absence of treaty ratification. In fact, the prohibition of torture is generally regarded as having the special status of a 'peremptory norm' of international law, and states cannot choose to disregard or derogate from it.

In addition to international law, many national laws will also include a prohibition of torture. However, the lack of a clear prohibition in domestic law will not release the state from its international legal obligations to refrain from and prevent torture under all circumstances, and to investigate allegations, punish perpetrators, and provide reparation to victims.

The prohibition against torture and other ill-treatment extends even to times of armed conflict, whether the conflict is international (between countries) or internal (within a single country). In times of conflict all parties have to refrain from subjecting anyone in their hands to torture and other ill-treatment,

whether they are combatants taking part in the fighting, whether they no longer take part in the fighting (e.g. due to being detained, or being wounded or sick) or whether they are civilians. International humanitarian law, of which the Geneva Conventions form a part, contains laws protecting people in times of armed conflict. The prohibition against torture in humanitarian law is expressly found in a number of provisions of the four 1949 Geneva Conventions and their Additional Protocols of 1977. An act of torture committed in the context of an armed conflict is a war crime.

Torture is also considered to be a crime against humanity when the acts are perpetrated as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict.

Under international law, the use of torture can be regarded as both the responsibility of the state itself and engage the individual criminal responsibility of persons involved. Those who carry out the act of torture can be tried in domestic and international courts.

In summary, the strong and unequivocal prohibition of torture means that torture can never be justified, in any situation, including public emergencies and even war. No case of torture, whatever the circumstances, can be ignored.

2.2 (b) Definition of torture

2.2 (b) (i) Definitions of torture and other ill-treatment

The most widely accepted definition of torture is to be found in the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), adopted in 1984: 'any act by which ***severe pain or suffering*** , whether ***physical or mental,*** is ***intentionally*** inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted ***by*** or ***at the instigation of*** or ***with the consent or acquiescence of*** a ***public official*** or ***other person acting in an official capacity*** . It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.' (Emphasis added.)

Other treaties and declarations also contain definitions of torture, sometimes with slight variations, though the essence remains the same.

The World Medical Association (WMA), in its Declaration of Tokyo (1975), defined torture more broadly as: 'the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting

alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason'.

2.2 (b) (ii) Key elements of torture

The key elements for the determination of torture are:

- The intentional infliction of severe physical or mental pain or suffering
- By or with the consent or acquiescence of the state authorities
- For a specific purpose, such as gaining information, punishment or intimidation.

2.2 (b) (iii) Other ill-treatment

In addition to the absolute prohibition of torture, there is also a wider prohibition of cruel, inhuman or degrading treatment or punishment. These are legal terms, describing forms of ill-treatment, also banned by international law. Ill-treatment does not have to be inflicted for a specific purpose, but there does have to be an intent to expose individuals to the conditions which amount to or result in the ill-treatment. Exposing a person to conditions reasonably believed to constitute ill-treatment will entail responsibility for its infliction. Degrading treatment will usually involve humiliation and debasement of the victim. The essential elements which constitute ill-treatment not amounting to torture would therefore be reduced to:

- Intentional exposure to significant physical or mental pain or suffering
- By or with the consent or acquiescence of the state authorities.

2.2 (b) (iv) Relationship between torture and ill-treatment

Determining the boundaries between torture and other ill-treatment, and between different types of ill-treatment, can be a difficult task. In most instances it is courts and other authoritative bodies that decide on a case-by-case basis which category may apply, while the role of the doctor is to provide the objective clinical findings of the case without necessarily forming a judgment on whether the treatment was degrading, inhuman or torture. Both torture and other ill-treatment will involve significant suffering and will be caused by or with consent or acquiescence of state or other authorities exercising effective power.

The health professional or other individual investigating and documenting allegations of torture, should document his or her findings, but leave the precise legal interpretation to the legal bodies.

2.2 (b) (v) The use of the terms 'torture' and 'ill-treatment' in this Handbook

Both the terms of torture and of ill-treatment appear throughout this Handbook. While torture in a strictly legal sense does not include all forms of ill-treatment, for the sake of simplicity and clarity in some instances this Handbook will employ the term 'torture' as a shorthand term implying 'torture and all other ill-treatment'. While there are differences of legal definition, within the context of this Handbook the reader should view torture and ill-treatment as interchangeable. As noted above, health professionals need not concern themselves whether the definition of the abusive act was torture or other ill-treatment. Similar legal and ethical rules apply to most cases of torture and other ill-treatment, and any form of these will always be contrary to international law and thus illegal. The individuals who

have suffered from torture and all other ill-treatment equally deserve that investigation, documentation, medical treatment and rehabilitation should take place with utmost efficiency and expedition.

2.3 Methods of torture

Any type of torture can have physical, mental as well as social impact on the victim. Therefore, it is artificial to classify torture as physical or mental. However, for our discussion in this paper, it has been divided into:

A. Physical Torture

B. Psychological Torture, and

C. Sexual Torture

2.3 (a). Physical Torture

Physical methods of torture are those methods which inflict pain, discomfort and dysfunction in different parts of the body.

Killing the victim is not the aim of torture. Therefore, the torturer takes care that the victim does not die during the torture. The torturer also takes care that the torture inflicted upon the victim is either undetected or detected only slightly by an ordinary examination. Therefore, torturers are trained to torture in such a way that these two precautions are well taken care of. However, despite all precautions, physical torture always leaves a sign that eventually leads to its discovery. It is something like a crime. The criminals take all the possible precautions to hide the crime and to hide themselves from the crime. The crime nevertheless always leaves behind some clues that ultimately lead to its discovery and to the criminals. Similarly, medical science has now developed to such an extent that the internal damage caused by such types of physical tortures can be detected even after several years of incidence.

***Types of Physical torture*:**

Physical torture can be inflicted in many ways but the commonly reported ones can be classified under four categories:

1. Physical torture that cause extreme and excruciating pain
2. Physical torture that cause fear of immediate death
3. Physical torture that cause extreme exhaustion.
4. Physical torture that cause disfiguration, mutilation and permanent disability.

2.3 (a) (i) Physical tortures that cause extreme and excruciating pain:

- ***Beating and Severe Beating:***

It is the most common type of physical torture used by perpetrators. Beating becomes severe when it is carried out by using sticks, cables, whips, iron rods, chains, belts or any other instruments. Similarly, punching with fists, kicking with feet, etc. are also considered severe

beating. Therefore, simple beating means slapping in some less sensitive and less delicate parts of the body which does not cause significant external and internal damage in the body. Slapping the ears cannot be considered a beating as it can damage the tympanic membrane and permanently affect hearing.

The impact of severe beating depends not only on the instrument used but also on the body parts involved. Therefore simply saying severe beating is not enough. It is essential to describe the instruments used the body parts involved, and also the duration and severity of the beating.

- ***"Falanga" torture:***

Severe beating on the soles of the feet is known as "falanga". Though it does fall under the heading of severe beating, it has been described separately since it is one of the most common types of systematic torture used in our country and in many countries around the world. Besides, this type of torture has immediate and long—term consequences, sometimes making a person disabled for several years or for ever. The pain continually reminds the victim of the torture and thus handicaps his/her recovery. Falanga can be given in many ways the victim may be suspended upside down and then beaten on the soles; the victim's legs may be fixed into a turung1,* etc. Any technique that can immobilize the legs and feet can be used for "falanga".

- ***Finger Torture:***

Pencil or similar objects are put in between two fingers which are then pressed hard together against the objects. Similarly, fingers may be twisted to cause severe pain. Pins may be pricked into fingers.

- ***Suspension:***

The victim is suspended by his legs or arms. The victim may also be suspended by his/her hair. Suspension is usually combined with other forms of tortures like severe beating, falanga, electrical torture, heat, cold, etc. Some of the special types of suspension are the "Palestinian suspension", " barra" etc.

- ***Cold Torture:***

The victim is subjected. to varying degrees of cold in different ways. S/he may be forced to sleep on a damp floor; s/he may be forced to stay naked in extremely cold weather. Some of the Bhutanese refugees in Nepal narrate that they were forced to completely undress and roll on the snow for a long period.

- ***Heat Torture:***

The victim may be forced to stand for hours under the sun in an atmospheric temperature of more than 30 degree Celsius. S/he may also be forced to kneel down near a fire, etc. Cigarette burn is the most common type of heat torture reported.

- ***Irritant torture:***

  Some irritants such as chilly powder, table salts, etc. are applied on a delicate body part or at times on an open wound. Sometimes, chilies may be burnt and the victim forced to inhale the smoke in a closed room for several hours.

- ***Made to walk or sit on sharp objects:***

  The victim is forced to walk without shoes over a thorny surface or on a ground full of broken glasses or nettles. S/he may be forced to sit on an object with pointed and sharp edges like a half-broken bottle, etc.

- ***Dental Torture:***

  Healthy teeth may be broken or pulled out with forceps. The victim may be asked to chew stone, wood, metal pieces etc.

- ***Ear Torture:***

  This is a common type of torture in Nepal. The victim's ear may be twisted or pulled away to such an extent that the external ear (pinna) is torn away. The torturer may ask one victim to torture another one in this way and vice versa.

- ***Hair Torture:***

  The victim may be dragged by the hair. The hair may be cut short or the head shaven altogether. Hair may also be burnt or pulled out forcibly.

- ***Scratching with knife:***

  The victim's clothes are taken off and scratches made in different parts of the body with a sharp knife, blade or similar objects. Lime juice and / or chilli powder with or without table salt may also be applied to these fresh scratches.

- ***Tied down:***

  The victim is tied down in many ways and then kept in this position for several hours or days. He may be suspended in this position and may even be beaten.

- ***Forced Position:***

  He may be forced to remain in abnormal strained positions for long hours. It could be done in many ways. On top of this forced position, he maybe exposed to kicks, blows, etc. or forced to carry heavy weights for hours.

- ***"Chepuwa":***

  This is a common type of torture reported by the Bhutanese refugees in Nepal. The victim's legs or thighs are clamped very tightly with bamboo sticks or similar objects causing severe pain to the victim.

- ***Twisting of Body Parts:***

The upper arms, the lower arms, the neck, etc. are twisted to such as extent that the ligaments in the associated joints are torn off causing severe pain to the victim even after the twisting is over.

- ***Poking:***

Poking the victim with a baton, rod or any other similar object is quite commonly reported by torture victims. Any part of the body may be poked.

2.3 (a) (ii). Types of physical tortures that cause fear of immediate death

- ***Electrical Torture:***

This is a very common type of torture used in Nepal. There are different modifications of electrical torture. Electric torture often involves sensitive parts of the body such as nipples, genitals, etc. It is often applied inside the mouth which is quite painful and difficult to detect later. At times, the victim is tied naked to a metallic bed and electricity applied to the bed so that the victim receives the shock all over the body. Sometimes the victim is soaked with water before applying the electricity so that the magnitude of the shock is greatly increased.

- ***Suffocation (Asphyxiation):***

The victim may be suffocated .in many ways. The victim may be suffocated to such an extent that s/he feels on the verge of death. The torturer usually stops the suffocation just before that happens. However, sometimes the victim may die during the process. Suffocation may also be done by closing the mouth and nose with some object or even with bare hands once the victim is tied down in such a way that s/he cannot move. When the victim's head is immersed in water, urine, vomit, blood, etc., it is termed 'wet submarino" or "la banera". In "Dry submarino", the victim's head and face is tightly covered with a plastic bag or any other similar item.

Suffocation may also be caused by strangulation, using hands, rope, belt or any other similar object.

- ***Sham Execution:***

This is a well-known and frequently reported form of torture, and can be done in many ways. The perpetrators may blindfold the victim and place him before a wall. They tell him/her that a vehicle is going to run over them and that they are going to die. The victim then hears an engine starting and coming towards him/her at full speed. However, just as it gets really close to him/her, it screeches to a halt.

2.3 (a) (iii). Types of physical torture that cause extreme exhaustion:

- ***Physical Exhaustion:***

Here the victim is forced to stand or do gymnastics for a prolonged period of time. The victim is asked to stand on one leg or both legs. S/he may be asked to stand on his/her head with legs

in the air or supported on the wall for a prolonged period. Commonly used methods is to stand with both the upper arms outstretched and with bricks on both hands.

- ***Forced Labor:***

This is a very common type of physical torture reported by torture victims in Bhutan and also in Nepal. The victim is made to work very hard without food and water and without any wages. They are forced to clear forests, break stones, dig ditches, etc.

2.3 (a) (iv). Types of physical tortures that cause disfiguration, mutilation and permanent disability:

- ***"Telefono"***

Simultaneous beating of both ears with the palms of the hands is known as "telefono". This ruptures the tympanic membrane causing pain, bleeding and hearing loss. However, it is difficult for an ordinary doctor to detect this.

- **Mutilation:**

Chopping off ears, nose, fingers, etc.

- **Disfiguration:**

Acid, and other corrosives thrown on the face, etc.

2.3 (b). Mental torture

Psychological methods of torture can be classified into following categories

1. Deprivation Techniques
2. Coercion Techniques or Compulsion Techniques.
3. Threats and Humiliation
4. Communication Techniques
5. Pharmacological Techniques

2.3 (b) (i). Deprivation Techniques:

As the name suggests, the victims are deprived of various necessities so that they are mentally tortured. These techniques can further be divided into:

a. Sensory Deprivation:

The victim is deprived of various sensory stimuli such as light, sound, etc. The victim may be blindfolded, hooded, kept in a dark room, and so on.

b. Perceptual deprivation:

The victim is deprived of perceptions so that he is disoriented and confused. Examples are:

- Frequent transfer of the victim from one place to another while blindfolded.
- Frequent disturbances of sleep.

- Deprivation of letters, use of radio, telephone calls, television, newspapers, books, calendars etc.

c. Social Deprivation:

- Not allowed to see visitors
- Not allowed to perform religious rituals
- Confined to an isolated cell

d. Deprivation of Basic needs:

- deprivation of food, water
- deprivation of ventilation
- deprivation of toilet facilities
- deprivation of sleep
- deprivation medical facilities
- deprivation of clothes
- deprivation of adequate physical space, etc.

2.3 (b) (ii). Coercion techniques:

In these techniques, the victim is compelled or coerced to perform activities or to witness actions that torture him mentally. These techniques can be further divided into:

a. Impossible choices:

The victim is compelled to choose between two alternatives that are equally bad and cause mental torture.

b. Incongruent actions:

- Signing of false statements
- Disclosure of information
- Forced to commit blasphemous acts
- Forced to violate social taboos
- Forced to witness torture of other victims. Forced to torture other victims.

2.3 (b) (iii). Threats & humiliation:

- Threats directed at the victim; shame execution
- Threats directed towards the family members, relatives, friends etc.
- Humiliating remarks and actions

2.3 (b) (iv). Communications techniques:

The victim is mentally tortured by exposure to a variety of confusing, contradictory and false communications. These techniques can further be divided into:

a. Misinformation:

The victim is given wrong and false information so that he is mentally tortured.

b. Conditioning Techniques:

The victim is further tortured whenever he does not comply with the torturer's demands. Similarly, he is given better food, better facilities, etc. whenever he yields to the demands of the torturer.

c. Double-Binding Techniques:

The victim is brutally tortured followed by seemingly humane and sympathetic treatment from another person or from the same torturer.

d. Reverse - Effect Techniques:

Torture is continued in spite of submission to every demand of the torturer.

2.3 (b) (v). Pharmacological techniques:

Various drugs are used to torture the victim, to facilitate torture, to mask the effects of torture and so on. These are:

- Use of drugs to induce self-disclosure by CNS depression such as alcohol, etc.
- Use of muscle - relaxants such as curare to the point of asphyxiation
- Pain—inducing drugs
- Hallucinogens
- Psychopharmacological drugs, etc.

2.3 (c) Sexual torture

Sexual torture could have been included under the heading of physical torture. But it has been described here separately because of its great social and psychological impacts. It can be divided into the following three categories:

i. Sexual Torture using instruments:

- Penetration of the vagina or anus by batons, rods, bottles or similar objects
- Suspension of weights on the penis and scrotum
- Electrical torture of the sexual organs.
- Mutilation of breasts, genital organs, etc.

ii. Sexual Torture without the use of instruments:

- Verbal sexual abuse and humiliation
- Undressed in front of others
- Rape by person of the opposite sex.
- Rape by person of the same sex.
- Squeezing breasts.
- Forced to masturbate in front of others
- Forced to witness the sexual torture of others
- Forced to perform sexual torture on other victims.
- Forced pregnancy
- Being photographed in humiliating positions and situations.

iii. Sexual torture by using animals:

- Rape by trained dogs, monkeys, etc.
- Rats, mice, spiders, lizards, etc. introduced into the vagina or anus

It is important to remember that all methods of torture - physical, mental and sexual - take place simultaneously in most of the cases.

2.4 Consequences of Torture

Consequences of torture can be broadly divided into:

A. Physical

B. Psychological and

C. Social

2.4 (a) Physical Consequences:

They are divided into early and late consequences.

2.4 (a) (i). Early consequences:

Depending on the type of torture given and its duration and severity, several external and internal signs of torture may be seen in the early days of torture. They are as follows:

- ***Abrasions:***

  Scab formation takes place within a couple of hours and this gets hard in about 12 to 24 hours. If the abrasions are small, the scab may peel off in 3 to 4 days but it may take from 10 to 14 days in cases of larger abrasions.

Abrasions on the neck indicates strangulation. Abrasions in and around the mouth and nose suggest suffocation. Abrasions on the medial aspects of thighs, in and around anus and the genital organs indicate sexual violence.

- ***Bruises:***

In bruises, the deeper tissues show an effusion of blood as a result of the rupture of the blood vessels due to the blunt trauma. These effusions may be large like a haematoma, small or even of the size of a small pinhead. This pinhead—sized collections of blood are known as ecchymoses.

The colour changes in the bruise depend on its size. In ecchymosis, skin may get normal appearance in 3 to 4 days time. In a bruise of average size, the color changes are as follows:

- red in the beginning
- blue, bluish—black, brown or livid red in the next 3 days
- greenish from the 5th to 6th day
- yellowish from the 7th to 12th day
- This yellow colour slowly fades in tint from the 13th day and the skin regains its normal appearance by 14th to 18th day.

- ***Haematoma:***

Because of the bleeding into the skin and muscles during torture, painful, swollen and discoloured areas may be seen in different parts of the body. Haematoma usually resolves within one to two weeks depending on its size and site.

- ***Laceration:***

May be seen in different parts of the body and may heal within two to three weeks.

- ***Incised Wound:***

Depending on its site and size, it may heal within two weeks.

- ***Penetrating wounds:***

Because of deep-seated injury, this wound is much more painful it looks on the surface. It can injure muscles, blood vessels, ligaments and other deep—seated structures. Depending on its site, the healing may take a week to several weeks.

- ***Sprain:***

Because of pull and push and suspension of different parts of the body, ligaments may tear off in different joints of the body. This causes local swelling and tenderness. Depending on its site and severity, the healing may take several weeks.

- ***Strain:***

The muscles may be overstretched and strained during suspension and forceful pufl on an extremity, etc. This may take several weeks to heal.

- ***Burns:***

  Marks of electrical burns, cigarette burns, etc. may be seen. The burn may be of any grade and, depending on its grade and site the healing may take a few days to several weeks to several months.

- ***Dislocation:***

  Dislocation may take place in shoulder joints, elbow joints, temporomandibular joints, hip joints, etc. depending on the site and the nature of trauma subjected to. This causes local swelling, deformity, tenderness and loss of function in the affected joints.

- ***Fracture:***

  Fracture of teeth and fracture of bones may be seen. The fracture may be open or closed. Local swelling, deformity, tenderness, loss of function, etc. should arouse suspicion• of fracture of the underlying bone.

- ***Dependent Oedema:***

  May be seen in different parts of the body depending on the type of torture and the region involved.

- ***Sexually Transmitted Diseases:***

  Acute gonociccal infection primary chancre, etc. may be detected.

- ***Abdominal injury:***

  Severe abdominal pain, rising pulse rate, falling blood pressure, pallor, cold and clammy extremities, dizziness, etc. should arouse suspicion of internal bleeding because of injury to the abdominal viscera. Haematemesis, malaena, haematuria may also be seen.

- ***Chest injury:***

  Massive haemoptysis may indicate injury to the lungs. Sudden onset of breathing difficulty may indicate pneumothorax, haemothorax etc.

- ***Genital injury:***

  External and internal genital organs should especially be examined for signs of torture as sexual torture is quite common but usually unreported because of social stigma and shame. Lacerations, haematomas, abrasions, burns, bleeding, infection, etc., may be seen.

- ***Head injury:***

Any history of head injury, however minor, should be taken seriously when the victim has vomiting, persistent headache, double vision, dizziness, drowsiness, loss of consciousness, history of amnesia, etc.

2.4 (a) (ii). Late Consequences:

These could be:

- Infections
- Scars
- Malunited bone
- Deformed body parts
- Disfiguration of the face
- Mutilation of body parts
- Abnormal gait and posture
- Impairment of hearing
- Impairment of vision
- Broken teeth/bone
- Closed compartment Syndrome associated with falanga torture
- Dislocated joints
- Muscles Atrophy
- Tendinitis/tendon rupture
- Chronic pain, especially backache, headache and shoulder pain
- Hyper/Hypomobility of joints
- Missing teeth
- Vertigo S
- Peripheral nerve damage
- Broken or missing nails
- Fibrosis of muscles, fasciae and connective tissues
- Dysfunction of various joints in the body
- Atrophy of testes
- Hydrocele
- Sexually Transmitted Diseases, including HIV/AIDS
- Vague Somatic Symptoms etc.

Falanga torture is of special importance as it is very common in our country and has many sequelae. Some of the important late sequelae of falanga torture are as follows:

Symptoms:

- Pain in the calves and feet

- Change in gait
- Low backache
- Feeling that knee and ankle joints are not supporting well and they are falling apart
- Feelina of heaviness in the thighs and legs
- Tingling and pricking sensations in the calves and in the feet
- Increased sweating of the feet
- Feeling of alternate heat and cold in the feet.

Signs:

- Smashed heel and forefoot pads
- Hard and rough scars in the skin of the soles of the feet
- Hyperextension of the first tarsometatarsal joint
- Plantar aponeurositis
- Atrophy of the plantar muscles of the feet
- Fractures of tarsal and metatarsal bones
- Hyper/Hypomobility of joints in the foot
- Abnormal gait, etc.

2.4 (b) Psychological sequelae:

There are many psychological sequelae. The important ones as follows:

- Anxiety
- Depression
- Sleep disturbances
- Headache
- Poor Concentration
- Poor Memory
- Low self—esteem
- Distorted body perception
- Derealization
- Psycho-sexual problem
- Post—Traumatic Stress Disorder (PTSD)
- Neurotic Disorders
- Alcohol/Drug Abuse
- Seizures
- Dementia I Mental Retardation
- Psychotic disorders etc.

Out of these psychological sequelae, post—traumatic stress aisorder is of special importance. This disorder has been frequently reported in persons who have had an experienée of an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone. To diagnose post traumatic stress disorder, additional features of persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness and persistent symptoms of increased arousal should all be present simUltaneously for at least one month.

2.4 (c). Social consequences:

There are many social consequences of torture. Some of the important ones are as follows:

- ***Social Stigma:***

  Torturers may label victims as traitors, anti—national elements, etc. This label may have immediate and long—term negative impact on the individual torture victim, his family members and relatives. At times, even the community he belongs to will have to suffer because of this social stigma.

- ***Employment:***

  The victim may be dismissed from his job or may not get employment despite being an efficient worker. His family members and relatives may also face a similar fate. Government agencies may reject the victim's job application it he has a negative police record. Even private prospective employers may not want to hire victims out of fear of retaliation by the torturers.

- ***Confiscation of Property:***

  Some dictators may even confiscate the property of the victim on charges of antinational activities.

- ***Daily Social Activities:***

  The torture victim and his family members may face a lot d n in their daily lives. Their community could reject, avoid situations in which the victim and his family could suffer because of the attitude and behavior of the community. However, it can be said that all aspects of their lives could be affected by this.

  It is, therefore, not only the physical scars, physical pain, physical disability and deformity that continuously remind the victim of the torture but it is also the social consequences that keep on reminding the victim of the torture events. It, therefore, becomes a vicious circle in which the torture keeps recurring and the victim suffers for a long time the actual incident.

  Social consequences also differ for the two sexes. In an orthodox society where female chastity and purity are valued, a woman who is arrested and kept in custody for even a single night is believed to have been soiled. Consequently, she is rejected by her husband, her parents and the entire community. This situation propels many of them to commit

suicide. The conclusion is that while dealing with torture victims, we have to take into consideration all three dimensions of torture — physical, mental and social. Therefore, treatment of a torture victim requires an interdisciplinary approach involving medical personnel from different specialties, psychologists, social workers, physiotherapists, occupational therapists and many other service providers.

2.5 Factors Modifying the Consequences of Torture

There are many factors which modify the consequences of torture. These factors can be described under five headings:

1. Aims of torture
2. Characteristics of torture
3. Characteristics of torture victims
4. Characteristics of the Environment and
5. Treatment and rehabilitation.

2.5 (a) Aims of Torture:

As described earlier, there are many aims of torture. Severity of torture depends on the purpose behind it. If it is only to extract information from the victim then the torture given may not be as severe as when it is done with the purpose of destroying the personality of the victim.

2.5 (b). Characteristics of torture:

In a living being, it is not possible to isolate the body from the mind. Whenever a physical torture is given, mental torture automatically takes place and vice versa. Therefore, it is artifical to call a torture a 'purely physical one or a 'purely' mental one. However, in practice, we speak of physical torture, mental torture and sexual torture. Comparatively, mental torture is much more distressing and disabling than physical torture. Similarly, sexual torture to women is much more damaging than psychological torture. Physical tortures which cause permanent disfiguration, disability and mutilation also have a much more serious impact than those that cause only intense pain and distress for a short duration.

Duration of Torture:

The consequences are greater when the duration of torture is longer. When the torture is for a shorter period the consequences may be less.

- ***Severity of Torture:***

  Consequences of torture are directly proportional to its severity.

- ***Region of the body involved:***

  If the body part involved is very delicate and sensitive then the impact will be greater.

2.5 (c) Characteristics of Torture Victims:

- **Age:**

  The impact could be greater in children and the elderly than in young adults. This is because the coping strategies in children are not mature enough and in the elderly, they are quite 'rigid and not so easily adaptable.

- **Sex:**

  Females are physically, mentally as well as socially more delicate and sensitive than their male counterparts and accordingly the impact of torture could be more in females.

- **Personality:**

  The impact would probably be less in a mature and well adjusted person than in an immature and mal-adjusted one.

- **Willpower:**

  The impact could be less in persons with strong will power than in persons with weak will power.

- **Past Experience:**

  Past experience will probably help the victim to cope better with the torture.

- **Anticipation of torture:**

  Anticipation of torture helps the person to be mentally prepared for the torture and this may help to lessen the impact.

- **Preparedness for torture:**

  Preparing oneself physically as well as mentally for the possible torture situation helps to minimize its consequences.

- **Social Background:**

  The impact could be more in persons with good social background, who have been brought up with love and affection and never been involved in any criminal activities. Compared to them, the impact would be less in persons who often have had involvement in criminal acts and have been brought up in an insecure environment with a history of childhood abuse.

- **Physical and Mental health:**

  The consequences would be more in persons who are already sick, either physically or mentally, than in those persons who are h both physically and mentally.

2.5 (d) Characteristics of the Environment:

- **Family Environment:**

If the family members understand the suffering of the victim, give him/her sympathy, support and encouragement, it would apt as a soothing ointment in a fresh open wound. On the other hand, if they blame the victim for the torture and are unsupportive and unsympathetic, then could multiply the consequences of torture.

- **Social Environment:**

  If the society regards him as a terrorist, traitor or criminal and a source of possible trouble for the whole community, then it would increase the consequences of torture. On the other hand, if the community people accept him as an innocent person who stood up boldly against oppression, then the consequences of torture could be less.

- **State Environment:**

  In a country with a dictatorial regime, a person would not feel safe and secure even after his release from the custody / jail. He would constantly fear that any time and anywhere he could again be arrested and tortured.

- **Reaction of the group:**

  If the victim's group feels that he has deceived them and is a source of possible trouble, he could be ill-treated and even tortured by them. This would have a synergistic effect on the consequences of torture. On the other hand, if he is welcomed and accepted back in the group as a person who stood up bravely for the interest of the group, then it would have an antagonistic effect on the consequences of torture.

How does the family and social background affect the consequences of torture?

A supportive and sympathetic family and social background helps to minimize the consequences of torture in the following ways:

A. It is helpful for him/her to ventilate his/her emotions by narrating the torture incident to people who are trustworthy, sympathetic and helpful. This sharing of the experience with other people can have an immediate effect on decreasing his suffering.

B. Torture victims often think that they themselves are responsible for the torture and they are the sources of threats and dangers to their families, friends and relatives. This negative cognition is due to acute depression in the post-torture stage. However, if the family and community people are supportive, then this negative cognition would soon change and the guilt feelings would disappear.

C. A supportive family and community would help the victim solve daily problems. This would help to dissipate his ideas of hopelessness, helplessness and worthlessness. S/he regains his/her confidence and starts viewing life in a positive way.

D. The environment in a supportive family and community would be just the opposite to that of torture situations — predictable instead of unpredictable, safe instead of unsafe, controllable

instead of uncontrollable, and sympathetic and friendly instead of unsympathetic and hostile. Thus, it would help to neutralize the impact of torture situations.

2.5 (e) Treatment and Rehabilitation:

Identification of torture victims and their families, and their treatment and rehabilitation soon after the torture helps to minimize its consequences. All forms of treatment - biological, psychological and social - need to be initiated simultaneously by a joint team. The sooner the treatment and rehabilitation, the better is the prognosis. Therefore, detecting torture, identifying torture victims and their families soon after the torture are crucial factors in minimizing the consequences of torture.

2.6 Additional rules relevant to the prevention of ill-treatment

Ill-treatment and torture are most common during the initial phase of arrest but may well also occur during ongoing detention or imprisonment, so other internationally accepted standards for the treatment of prisoners can be applicable to the protection of prisoners. While these standards are not legally binding, they provide a useful set of norms and guiding principles which can be used by the international community in interpreting the above prohibitions on torture, cruel, inhuman or degrading treatment or punishment, and the obligation of humane treatment and respect for human dignity. The standards promoted by the United Nations (UN Standard Minimum Rules for the Treatment of Prisoners, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, and the Basic Principles for the Treatment of Prisoners) apply globally, whereas

others, such as the Standards of the Committee for the Prevention of Torture (CPT), and the European Prison Rules apply only regionally, in this case in Europe.

Health professionals should be aware of the specific provisions of these standards dealing with health care for prisoners and other persons held in detention. These include the availability of medical care, including physical and mental health care; segregation of prisoners with suspected contagious conditions; regular inspections of food, hygiene and sanitation. Non-observance of these standards can contribute to the creation of detention conditions that may well amount to ill-treatment.

Miguel Angel Estrella v. Uruguay, Communication No. 74/1980, U.N. Doc. CCPR/C/OP/2 at 93 (1990). UN Human Rights Committee

This communication was submitted to the Human Rights Committee by an Argentinean citizen (a concert pianist by profession) who had been detained and tortured in Uruguay. The case highlights the severity of suffering caused by psychological torture.

The communication contained the following description by the victim:

'The tortures consisted of electric shocks, beatings with rubber truncheons, punches and kicks, hanging us up with our hands tied behind our backs, pushing us into water until we were nearly asphyxiated, making us stand with legs apart and arms raised for up to 20 hours, and psychological torture. The latter consisted chiefly in threats of torture or violence to relatives or friends, or of dispatch to Argentina to be executed; in threats of making us witness the torture of friends, and in inducing in us a state of hallucination in which we thought we could see and hear chimes which were not real. In my own case, their point of concentration was my hands. For hours upon end, they put me through a mock amputation with an electric saw, telling me: "we are going to do the same to you as Victor Jara" [a well-known Chilean singer and guitarist who was found dead in the national stadium shortly after the 1973 coup, with his hands smashed]. Amongst the effects from which I suffered as a result were a loss of sensitivity in both arms and hands for eleven months, discomfort that still persists in the right thumb, and severe pain in the knees.'

Following their assessment of the case, the Human Rights Committee found that:

'On 15 December 1977, at a time when the author was about to leave Uruguay, he and his friend, Luis Bracony, were kidnapped at his home in Montevideo by some 15 strongly armed individuals in civilian clothes. They were brought blindfolded to a place where he recognized the voices of Raquel Odasso and Luisana Olivera. There the author was subjected to severe physical and psychological torture, including the threat that the author's hands would be cut off by an electric saw, in an effort to force him to admit subversive activities. This ill-treatment had lasting effects, particularly to his arms and hands.'

And that

'Miguel Angel Estrella was subjected to torture during the first days of his detention (15-23 December 1977).'

2.7 The perpetrators

2.7 (a) State actors (those who act on behalf of the state)

As is emphasized above [section 2.2(b)], the legal definition of torture implies that the behaviour in question be carried out by, or with the approval of, a representative of the authority in power. Considering the common purposes of torture, which may be to obtain information during an interrogation, or sometimes, to intimidate the population as a whole in the face of insurrection or disturbance, it is unsurprising that the principal perpetrators are those officials involved in the criminal investigation process, and those responsible for the security of the state.

This means that those most likely to be involved in torture and other forms of ill-treatment include:

1. The police
2. The gendarmerie (in countries where this institution exists)
3. The military
4. State intelligence agents
5. Paramilitary forces or other armed groups acting in connection with official forces

6. State-controlled counter-insurgency forces
7. Prison officers
8. Private contractors carrying out any of the above activities
9. Co-detainees or other members of the general population acting with the acquiescence of or on the orders of public officials.

Heaith professionals, even those not directly employed by the state, may also be involved in acts of torture and other ill-treatment. Doctors, psychiatrists or nurses might participate in torture either by direct involvement (be it through medical monitoring of the torture, certifying someone fit for interrogation, or even using medical knowledge to design or refine methods of torture or other ill-treatment), by assisting in a cover-up (for example, by issuing misleading medical reports), or by omission (such as failing to give necessary treatment). As noted earlier, torture is a crime, and any involvement in torture can lead to criminal charges being brought against those involved, including health professionals.

2.7 (b) Non-state actors

In addition, torture often occurs in the context of armed conflicts, particularly internal conflicts involving forces in opposition to the recognised authorities, and which exercise effective power. In such circumstances, torture and other forms of ill-treatment may also be inflicted, for example by opposition forces, who are also bound by customary international law and Geneva Convention standards to refrain from torture.

Furthermore, if an organised group, whether or not it is a party to an armed conflict, engages in acts of torture or other ill-treatment against a civilian population, on a systematic or widespread scale, it can be guilty under international law of violating the prohibition of torture or other ill-treatment.

2.7 (b) (i) Protection from third parties

The main focus of this Handbook is on torture and other ill-treatment by state agents, particularly law enforcement officials. However, there is also a growing acceptance of the importance of safeguarding people from similar treatment carried out by private groups or individuals. States are responsible for safeguarding the rights of everyone within their jurisdiction and may under some circumstances be held accountable for acts carried out by private individuals if it supports or tolerates them, or fails in other ways to provide effective protection in law and in practice against them.

2.7 (c) Obligation to investigate and bring to justice

The prohibition of torture is not limited to a negative obligation to refrain from causing suffering, but also contains wider obligations: including the obligation to investigate allegations and bring the perpetrators to justice. The UN Convention Against Torture (UNCAT) states clearly in article 12: 'Each State Party shall ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.' The next article adds an obligation to ensure that individuals have the possibility to lodge a complaint, and that this complaint be investigated.

The European Court of Human Rights has noted that without such a duty to investigate, 'the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance, would be ineffective in practice and it would be possible in some cases for agents of the state to abuse the rights of those within their control with virtual impunity'. The Inter-American Court of Human Rights has similarly found the failure to mount an effective investigation to be a violation of the right to be protected against torture and inhuman treatment.

Investigations should not be dependent on the lodging of a complaint. States must launch an investigation whenever there is reasonable suspicion that torture has taken place. The European Court of Human Rights has stated in this regard that where an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the state to provide a plausible explanation as to the cause of the injury. Since it is likely that health professionals would be amongst the first to discover any signs of abuse, the initiation of an investigation relies heavily on their awareness, assessment and subsequent action.

2.8 Situations in which torture allegations may arise

Torture may take place in any location and within numerous contexts. In some countries, torture is commonplace. Certain times and situations could, however, be considered as high-risk circumstances. These include conflict zones, and situations of political unrest or general violence.

Allegations of torture can come from a variety of sources and at different times. The primary source of information is clearly from the individuals themselves, and this could happen while in custody, immediately after release, or at a later date. The families of survivors are another extremely important source of information as the survivors of torture themselves may be unable, or unwilling, to speak out. In any of the descriptions below, the role of families should also be kept in mind. Information can also come from other sources, such as the media and the work of non-governmental organizations.

Health professionals may find themselves being called upon to assist with an investigation in addition to providing medical treatment. Documentation may range from clear, comprehensive notes that may be summarized later, to a full medico-legal report. Sometimes useful evidence can be gained from analyzing clinical data on survivors of torture and presenting them in a way that does not permit individuals to be identified.

Detainees are probably the segment of population most likely to suffer torture and other ill-treatment since this kind of abuse is usually inflicted while an individual is in some form of custody. The greatest risk of torture and other forms of ill-treatment to individuals is in the first phase of arrest and detention, before they have access to a lawyer or court. Furthermore, incommunicado detention (i.e. detaining somebody without allowing them access to anyone, such as their lawyer or family) is probably the single highest risk factor for torture because it means that there is no external monitoring of the detention and interrogation process.

It should also be remembered that while torture per se is less common once a person is on remand or sentenced and in prison, deliberately poor conditions of detention themselves, certain treatment or punishments inflicted by staff, or a failure to protect individuals from other prisoners, may also amount to forms of ill-treatment or, in some cases, torture.

2.8 (a) Formal inspection of detention facilities

There are a number of bodies that may have the ability to conduct regular inspection of detention facilities. These could be monitoring bodies from within the prison authority; governmental inspection bodies; independent ombudsmen; national human rights commissions; the office of the public defender or other bodies from within the legal system; international organisations; domestic non-governmental organizations (NGOs).

The International Committee of the Red Cross (ICRC) visits people deprived of freedom in times of armed conflict, to check that they are treated humanely and in accordance with international law (both humanitarian law and human rights law). The ICRC undertakes visits under nonnegotiable modalities which include: access to all places of detention and all people detained and to make a register of all those who wish to have their details recorded; the possibility to select individual detainees to talk with in private, and the possibility to repeat the visits as often as is deemed necessary. During visits, the ICRC takes the humane treatment of detainees to encompass not only freedom from torture and other ill-treatment, but also general conditions of detention that maintain both the physical and mental integrity of the individuals. Their findings are communicated and discussed on a confidential basis with the concerned authorities.

Other bodies, particularly human rights NGOs, are sometimes more likely to gain ad hoc permission to conduct an inspection, rather than regular access. On occasion, inspections might be limited by restricted access to the detainees, or detainees may be wary of complaining for fear of retribution. In such cases it is nevertheless often possible for the inspection team to assess the likelihood of prevailing ill-treatment, especially in relation to the physical conditions of detention. Most often, existing national oversight mechanisms will have most access to prisons, but may have less access to police stations. Access to interrogation centres and military camps may be even more restricted.

Recognising the vulnerability and need for enhanced protection of people in custody, the UN adopted an Optional Protocol to the UN Convention Against Torture in December 2002. This instrument creates a mechanism for regular inspection, by independent international and national bodies, of all places where people are deprived of liberty, within countries that agree to be bound by this Protocol.

2.8 (b) Official complaints to human rights bodies and other organizations

Allegations of torture and other ill-treatment can be presented to a variety of human rights bodies. Many countries have a human rights ombudsman or a commission which might receive and investigate complaints. This might also be a body with a specific mandate on treatment of prisoners. Additionally, there are numerous regional and international human rights mechanisms which can also, under certain circumstances, receive allegations. These include the UN Committee Against Torture, the UN Human Rights Committee, the UN Special Rapporteur on Torture, the UN Special Rapporteur on the Right to Health, the UN Special Rapporteur on Violence against Women, the European Court of Human Rights, the African Commission on Human and Peoples' Rights, the Inter-American Commission on Human Rights and others.

In situations where the ICRC is active, the humanitarian organisation can, under specific circumstances, receive allegations of arrest and detention of individuals and make direct enquiries of their whereabouts with the authorities and during visits to places of detention. If located, the ICRC is often able to put the detainee in contact with their family through a system of Red Cross Messages.

2.8(c) Recently released detainees

Individuals who have recently been released from detention or prison might seek medical and legal advice concerning their treatment while in custody. This could, in some circumstances, be their first opportunity to detail fully their conditions of detention and any ill-treatment they may have undergone. The continuing physical and mental effects of ill-treatment may also lead recently released detainees to seek medical treatment. The initial concern of the individual seeking medical care might be to receive treatment, rather than the actual allegation of torture, but good contemporaneous notes will help if he or she wants these effects to be documented in due course. The person giving advice or treatment should inquire sensitively into the possibility of ill-treatment, and advise on avenues of further action.

2.8 (d) NGO information gathering

Non-governmental human rights organisations, including medical organisations, or any other body engaged in monitoring and advocacy, may uncover evidence of torture and other ill-treatment during their work. Through a combination of meticulous research including field-work, interviews with survivors and families, meetings with public officials, information from the media, and cooperation between organisations, it may be possible to identify a pattern of human rights abuses that may not have been evident when viewing each source separately. This is often the way in which systematic torture and other ill-treatment come to light.

2.8(e) Late allegations

Given the traumatic effects of torture, evidence may be kept concealed by survivors before being disclosed by them much later. The newly disclosed evidence could be the result of a change in government or government policy which leads to an uncovering of the actions of their predecessors. Mountains of evidence can surface through various types of truth and reconciliation commissions which are working to uncover past abuses as part of a national healing process. Additionally, allegations might come to light at different stages of a legal process, even at quite late stages. There have also been cases when acknowledgement of torture practices appeared in interviews and publications of retired officials who had been responsible for acts of torture or other ill-treatment earlier in their lives.

SOURCES:

1) Michael Peel and Noam Lubell with Jonathan Beynon, **Medical Investigation and Documentation of Torture: A Handbook for Health Professionals**, Human Rights Centre, University of Essex, 2005. Available at http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

2) Borrowed from Dr. S. Sivayogan, ***Caring for Torture Survivors: Medical Aspects***, Family Rehabilitation Centre, Colombo, Nov. 2000, with modifications.

III. MEDICAL ETHICS

3.1 Introduction

Medical ethics broadly describes the moral framework in which health professionals are bound to carry out their work. Many of the rules and principles of medical ethics have been adopted as professional codes of conduct. While ethics must guide every action of health professionals in their work, in the process of investigating and documenting allegations of torture, there are three areas in which the health professional must be particularly cognizant of specific ethical considerations. The first is the duty to the patient, the second is the clinical independence of the health professional and the third is in the production of medical records, reports and testimony (the latter will be covered in section 4.5).

There are certain ethical issues which are more likely to come to the fore depending on the various situations in which health professionals may encounter those alleging or showing signs of torture. This chapter points out the particular ethical considerations raised by situations such as the examination of an individual who is brought to a hospital or clinic still in the custody of the police, military or other security forces, and difficulties encountered by health professionals employed by the police, military or prison authorities.

3.2 Duties of the health professional

Health professionals have a duty to treat all patients without any form of discrimination and to provide treatment based only upon medical criteria without outside influence. In cases where torture or other ill-treatment is suspected, the health professional must keep in mind that these are crimes under international law, and probably domestic law. Therefore, irrespective of what the individual may be suspected, charged or convicted, the health professional's duty is to document objectively any psychological or physical findings and, where pertinent, provide treatment or referral to colleagues for treatment. Thus those who become aware of torture have a duty to act, both to relieve the suffering and to document the evidence. To do nothing may be seen as acquiescence and as compounding the abuse. On the other hand, when choosing a course of action, consideration also needs to be given to the torture victim's situation and how the risk of reprisals can be avoided or minimized [see sections 3.2 (g), 3.2 (h), 3.2 (i), 3.2 (j), 3.2 (k)].

3.2. (a) International codes

Many UN documents address the specific ethical obligations of doctors and other health professionals, for example in Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment; Standard Minimum Rules for the Treatment of Prisoners; and the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). These documents

stress that it is a gross contravention of health care ethics to participate, actively or passively, in torture or other ill-treatment, or condone it in any way. Medical services must be provided for all patients without discrimination. They reinforce the ethical obligations of health professionals to act in the best interests of patients.

3.2. (b) Ethical rules directly prohibiting involvement in torture

A number of international ethical standards deal directly with the obligations of health professionals with regard to torture and other ill-treatment. The World Medical Association's 1975 Declaration of Tokyo, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, contains an unequivocal prohibition on any form of active or passive participation of a doctor in torture or other ill-treatment. According to the declaration:

> 'The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations, including armed conflict and civil strife.
>
> 'The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
>
> 'The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.'

Principles of medical ethics apply not only to doctors, but to all health care professionals. Nurses may also find themselves faced with patients who are survivors of torture or other ill-treatment, and the Position Statement on Nurses' Role in the Care of Prisoners and Detainees, of the International Council of Nurses, has stressed the fundamental obligation of the nurse to restore the health and alleviate the suffering of the patient, including prisoners, and to protect them from abuse and ill-treatment. Similarly, the World Psychiatric Association has issued specific guidance which prohibits any participation of psychiatrists in torture (Declaration of Madrid 1996).

'Participation' in torture refers to some action at the time of the abuse or later, or by omission. It includes evaluating an individual's capacity to withstand ill-treatment; being present at, supervising or inflicting ill-treatment; resuscitating individuals for the purposes of further ill-treatment; providing medical treatment on the instructions of those likely to be responsible for torture (rather than on the basis of clinical judgment); or providing professional medical knowledge or individuals' personal health information to torturers. Omission includes the deliberate withholding of medical treatment so as to aggravate suffering intentionally or neglecting evidence. The failure to report cases of ill-treatment or torture that a health professional has noted is at least acquiescence in torture, and the falsifying of medical notes or reports is a form of complicity in the abuse.

3.2. (c) Primary loyalty to the patient

The principles of medical ethics make it clear that the primary loyalty of the health professional is to the patient. While the health professional may feel bound towards the state as an employer or for ideological reasons, their first and foremost obligation is always to the patient. According to the Tokyo Declaration '...the doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.'

In fact, according to the World Medical Association's Declaration on the Rights of the Patient, 'whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them'.

3.2 (d) Dual obligations

Many health professionals have dual obligations (also referred to as 'dual loyalties'), in that they owe a primary duty to the patient to promote his or her best interests and often a separate duty to employers. There is also a general duty to society to ensure that violations of human rights are prevented, and that justice is done when they have already happened. The dilemmas arising from dual obligations are particularly acute, however, for health professionals working with the police, military, and other security services or in the prison system. In these situations, either through the fact of their employment or ideological reasons, the obligations to their employer (the state) as well as the interests of their employer and their non-medical colleagues may all be in conflict with the best interests of their patients. A military doctor, for example, may belong to the very same government forces to which suspected perpetrators belong, thus interposing the loyalty to their comrades, military unit and military objectives, between the obligation to the individual patient. A military or prison doctor may be under pressure to ignore allegations, or not conduct proper examinations and/or to falsify any record of their findings.

However, as a health professional, there is a particular duty to act impartially and to document and report any suspected ill-treatment through the appropriate channels. A health professional must only document that which they have personally verified themselves, and they must document this truthfully, fully and accurately. Health professionals must be able to make clinical decisions independently from employers, governments, and other bodies in order to act in the best medical interests of their patients. They cannot be obliged by contractual or other considerations to compromise their professional independence.

There are various situations in which dual obligations and other ethical and legal issues may arise:

- They could be asked to perform a medical examination prior to interrogation in order to verify that the individual will be able to withstand physical torture or other ill-treatment.
- They could be asked to revive or treat an individual during an abusive interrogation to enable further interrogation
- They may be asked to provide medical knowledge or individual medical information concerning physical health or to identify psychological weaknesses or fears, that can be exploited in order to facilitate interrogation, or to develop new methods

- Health professionals could be asked to be complicit in the falsifying of medical reports in order to cover-up any indications of abuse.

Health professionals undertaking the above tasks may be guilty of playing an active or passive role in the abuse of an individual. In all these cases the health professional must abide by the rules of medical ethics and retain their primary loyalty to the patient, refusing to participate in or condone torture or other ill-treatment, and doing all they can to end the abuse, including the full and accurate documentation of any possible psychological or physical sequelae.

It should be kept in mind that in addition to the principles of medical ethics, health professionals working for the state are also bound by the rules of international law (see section 2.2) and which could in certain cases lead to individual criminal responsibility of the health professional for participation in torture. Obeying the orders of a superior would not provide a defense to a charge of participation in torture.

Forensic doctors may have a different relationship with individuals they examine. In their usual function, the main duty of the forensic doctor is to the courts, to which they provide independent medical expert opinion, even though they may be paid by one or other party. Before beginning any examination, forensic doctors must explain their role to the individual and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context, as their primary duty is to objectively document evidence that can be presented to a court. However, forensic doctors should not examine individuals without making clear the nature of their role and gaining specific consent. If consent is refused, this must be noted and respected. Depending on the jurisdiction, following such refusal by the subject, a court order may be required before any examination or taking of samples can proceed. The forensic doctor should seek to include in their findings and report, only that medical information that is relevant to the case, and should leave out that medical information which can remain confidential to the patient (e.g. if HIV status is not relevant to the case, then it should not be raised in the findings). They must not falsify their reports but provide impartial evidence, including making clear in their reports any evidence of ill-treatment.

3.2 (e) The treatment of prisoners and detainees

The rules of medical ethics and medical professional codes do not allow for discrimination in the provision of health care to prisoners and detainees. Individuals under arrest or any form of detention must have access to a standard of health care and services, and compassionate care, which are equivalent to that of the surrounding general population. This applies to health professionals who work directly in prisons or other detention centres, and equally to health professionals working in the national health services to whom prisoners may be referred.

3.2 (f) Issues surrounding examinations of individuals in the presence of security forces

Health professionals, whether working in places of detention, called to visit a police station or other place of detention, or working in national health services, may well be presented with detainees to

examine in the presence of security forces. The reasons for such examination may include a statutory initial medical examination upon arrival in a place of detention, complaint of illness or ill-treatment by a detainee, or routine referral for medical treatment. When faced with a detainee, the health professional must apply their usual ethical principles in any assessment and treatment. The detainee must give informed consent to any examination, procedure or treatment, and this should include an explanation of who will have access to any findings, and how these findings may be used.

Two further points of particular importance in the examination of detainees must be highlighted: the maintenance of medical confidentiality and the use of restraints (such as handcuffs) on detainees. Medical ethics dictates that consultations and the information gained therein should be confidential between the doctor and the patient. In the case of prisoners, the security forces (police, military or prison guards) will often maintain that they must remain present during any consultation, the most common reason being that it is for the protection of the health professionals. In some circumstances, the security personnel might insist that the detainee remain in restraints (handcuffs, ankle-cuffs) and even with a hood or blindfold during the consultation. Thus there is an immediate conflict between security and medical concerns.

As stated above, health professionals have a duty to observe their usual ethical practice in their treatment of detainees. In brief, there can be no blanket rule that dictates that all detainees are dangerous and merit in all circumstances the presence of security personnel and/or restraints. If escape is an issue, health professionals can conduct consultations with the security personnel outside the door, or as a less acceptable alternative, with the door open and the personnel out of range of hearing. Further, security concerns can be addressed by conducting the consultation in a room that has only one entrance, and either no windows or barred windows.

The routine use of restraints during medical consultation or treatment is also contrary to medical ethics and international standards on treatment of prisoners, and health professionals must not accept such practices. Restraints not only interfere with the proper diagnosis, management and treatment of patients, but they also run contrary to the inherent dignity of all human beings. The only possible acceptable justification for use of restraints is as a last resort when there is substantiated reason to believe that this particular detainee presents an immediate and current violent threat to himself or others. Health professionals can and should question the use of restraints if they have reason to doubt such a risk exists. In the exceptional circumstances that restraints are used, they should be as minimal as possible.

The use of hoods or blindfolds during any contact between a detainee and health professionals is absolutely unacceptable under any circumstances. The use of hoods or blindfolds has in itself been found to be a form of ill-treatment. In the health setting hoods or blindfolds not only impair any meaningful contact with the patient, they also prevent the identification of any health professionals and may thus add to a perception of impunity in any cases of ill-treatment.

3.2 (g) Abusive medical treatment

Health professionals should also be wary of any attempts to ask them to administer treatment or

medication that are not aimed at benefiting the physical or mental health of the patient, but only at assisting an interrogation or the management of a patient or detainee.

The individual need not be in prison, or in detention at all, to be tortured. Health professionals must be aware that they might be considered responsible for ill-treatment in settings where patients do not have freedom of movement, for example those detained under mental health legislation or in facilities for the elderly. Inappropriate use of medical treatment, such as overuse of sedatives, may also be ill-treatment.

3.2 (h) Consent and confidentiality

It is a principle of ethical practice that patients must understand what is happening to them and consent to it. This is extremely important in working with torture survivors who have been in the situation of having no control over any aspect of their lives. It is essential they do not feel powerless in the subsequent clinical setting. This is particularly true of medico-legal work in which the documentation will be in the public domain. For consent to be valid, the patient must understand how the data gained from the examination will be used, how it will be stored and who will have access to it.

While all statements emphasize the obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what is in the patient's interests. A fundamental idea in modern medical ethics is that patients are the best judges of their own interests. This requires that health professionals should normally give precedence to the competent adult patient's wishes. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgment about how that person's best interests can be protected and promoted. Nurses and doctors are expected to act as the advocate of their patients' well-being and this is made clear in professional statements.

Conflicts arise where health professionals are pressured or required by law to disclose information to third parties about patients without consent. This may include an obligation to report torture or serious crimes (possibly including torture itself). A health professional may receive an allegation of torture on the patients' understanding that they are only seeking treatment and that the information will not be disclosed to others for fear of reprisals or other reasons. The health professional must contemplate the risks to the patient, and indeed to themselves, in disclosing such information, and the potential benefits to society as a whole (e.g. potentially avoiding further harm to others), before acting. Whatever decision is reached the health professional should endeavour to gain consent. In such cases, the fundamental ethical obligations to respect autonomy and to act in the best interests of the patient are more important than other considerations, although the duty to avoid harm includes that to third parties. Health professionals should make clear to any authority requesting information that they are bound by professional duties of confidentiality. Health professionals responding in this way are entitled to the support of their professional association and colleagues.

The Geneva Conventions give particular protection to doctor-patient confidentiality in periods of international armed conflict, for example, requiring that doctors should not be compelled to disclose information about their patients to the opposing side.

3.2 (i) Security

The security of the individual who may complain of or show signs of ill-treatment is closely related to the issues of consent and confidentiality described above. In examining or treating these individuals, the health professional must keep in mind the security of both the patient and themselves. Often, the patient may have the impression that the health professional can provide an element of physical protection, and even prevent further arrest or ill-treatment. This sense of protection may be even more commonplace when health professionals visit the individual while they are still detained (particularly if it is a visit by an international team) since it is assumed that the fact of having access to the place of detention invests them with greater powers.

The security of the individual extends to how any information collected is used or to whom it is divulged. Clearly the release of any information is governed by the issues of consent and of confidentiality since identifiable information may itself lead to recriminations for the individual, or their family, or indeed the health personnel. Health professionals thus have a duty to ensure that individuals are aware of the limits of their ability to protect them, and must ensure that no information is released or passed on that may put interviewees at risk. All documentation must be stored safely.

3.2 (j) Involvement of other health professionals in torture

Health professionals may at times have concerns that other health professionals might be participating directly or indirectly in the torture or other ill-treatment of individuals. The appropriate course of action in such cases can depend on the particular circumstances, for instance whether the concerned health professional is working within the same institution as those he or she suspects; whether he or she is a local practitioner or part of an international visiting team; and the assessment of level of risk that may be involved in various courses of action. In some cases, a private discussion with trusted colleagues may be enough to clarify and bring about positive change. In other cases, there may be a need to turn (sometimes discreetly) to outside bodies, national or international (such as medical associations or human rights bodies), in order to seek advice.

3.2 (k) Seeking further information and support

Health professionals who encounter any of the above situations, and have concerns on how to act, can seek information and support from a variety of bodies, national and even international, who may be able to provide more specific guidance. If within the police, military or prison medical services there are ethics bodies, then this could be one avenue, although in many contexts these bodies may effectively be unable to work impartially, or the health professional may feel that turning to these bodies could present a risk of personal security to themselves or the patient. Other bodies the health professional could perhaps turn to include national medical associations, national human rights bodies, or, if these are not available, relevant international bodies, in particular the World Medical Association (WMA).

SOURCE: Michael Peel and Noam Lubell with Jonathan Beynon, **Medical Investigation and Documentation of Torture: A Handbook for Health Professionals**, Human Rights Centre, University of Essex, 2005.

Available at http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

IV. GENERAL GUIDELINES FOR GATHERING EVIDENCE AND DOCUMENTING FINDINGS

The primary goal of documenting allegations of human rights violations is to create an accurate, reliable and precise record of events. The uses to which this record may be put are varied, but all rely on the quality of the record that has been established. This chapter sets out the basic guidelines for embarking on an investigation into torture allegations. A description of a typical documentation team is given, detailing the different roles and functions carried out by each member. A general overview of documentation is provided, to illustrate for the health professional how the medical evidence fits into the wider picture of documentation and evidence. It also covers essential information needed in any investigation of allegations, including types of evidence which the health professional should attempt to gather when the lawyer is prevented from doing so. General guidelines are given on the types of evidence needed, what essential information should be collected, how to ensure the quality of information, and various considerations to be taken into account in the gathering of evidence. The compilation of medical documentation, including medico-legal reports detailing the findings of an investigation into torture allegations, is addressed in the second half of this chapter.

4.1 The aims and goals of investigation

Torture and other ill-treatment are prohibited in international law and are likely also to be a crime under national law. International law requires not only that torture not be used, but also that any allegation of torture be investigated, and that those responsible be brought to justice.

Effective investigation, including the aspect of medical documentation, is a vital component in the struggle to eradicate the practice of torture. Legal bodies, domestic and international alike, rely on factual evidence to reach their conclusions and uphold justice.

By shedding light on cases of torture and other ill-treatment, effective investigation and documentation can assist

in the achievement of a number of important goals:

- Raising awareness of the infliction of torture and its absolute prohibition
- Battling impunity: bringing torture into the public eye assists in calling states to account for their actions and having them fulfill their legal obligations. On a different level, torture reporting can also
- help to cast light on the individuals who carry out such practices, to make sure that they cannot continue
- to engage in such behaviour without negative consequences
- Redress for the survivor: there are a number of remedies and objectives that may assist the individual survivor of torture, for example

- Preventing and ending ongoing abuse: in certain cases, allegations of torture may be raised by a person who is still in custody of the authorities. Effective and swift investigation can help put an end to the suffering. In other cases, the individual may be seeking protection from abuse in another country, and the determination of whether the individual was a survivor of torture and is personally at risk can prevent the person being deported back into the hands of their torturers
- Compensation and other forms of restitution: survivors of torture may, for example, be able to claim compensation for monetary loss, physical and mental harm, and other damage caused by the torture
- Rehabilitation: many torture survivors are in need of rehabilitation services, including medical treatment, both physical and psychological, legal assistance, and social services. Effective investigation and documentation can assist in diagnosis, treatment (including rehabilitation) and prognosis of the patient
- Official and public acknowledgement of their suffering can also be important in the recovery process of survivors of torture.

- Reform: drawing attention to a situation is not just about seeking condemnation or holding a state to account. Even more importantly, it is about seeking constructive and long-term improvements in a country which will contribute to the ultimate elimination of torture. This will often require changes both in the legislative framework and in official attitudes to torture. The eradication of torture is a fundamental and necessary step for any society aspiring to protect human rights and care for its people.

4.2 Multidisciplinary approach to documentation

Although straightforward allegations of torture can be documented by a health professional on his or her own, the investigation and documentation of torture is ideally a joint effort to be carried out by a number of actors with expertise in different fields. These usually include a lawyer, health professional and human rights monitor. Others who play an important part in the effort are judges, the police, the media, and of course the individuals and their families.

4.2 (a) Role of the health professional in the team

Health professionals who encounter survivors of torture may do so in different capacities, and they may thus have slightly different but convergent duties:

- The health professional who is asked to examine an individual expressly for the purpose of providing a medical opinion in a report for a court or other judicial body will be fulfilling a forensic (medico-legal) role
- A health professional who is acting as a care giver to an individual and who in the course of routine work notes signs and symptoms of ill-treatment, or to whom the individual complains of being previously subjected to ill-treatment, may need to make an accurate

medical record of the findings in the medical notes

- A health professional who forms part of a team visiting places of detention may record findings of ill-treatment in individuals, but this information may be used more generally in a report on the place of detention without actually forming part of a medico-legal report.

The first and foremost concern for the health professional is the immediate health and well-being of the torture survivor. Health professionals may have a therapeutic role in treating the patient, or a forensic role in establishing the possible causes and origins of injuries and trauma. There are concerns that having a dual role may create the perception of bias in the reporting. The health professional should therefore ensure that the individual is receiving any necessary medical care, taking into account that:

- Care includes immediate treatment and long-term rehabilitation for survivors of torture
- Forms of torture may be used that are psychological or otherwise leave no persisting physical signs. It must always be emphasised that the absence of physical or psychological findings can never be considered to be evidence that ill-treatment did not occur
- A psychological assessment of the individual should take place, noting any psychological effects that may be the result of torture or other ill-treatment
- The strongest evidence supporting the allegation of torture is often of a medical or psychological nature. The health professional should record any external or physical evidence of injury or abuse and any psychological symptoms and signs.

4.2 (b) Role of the lawyer in the team

- The lawyer is the primary link between the torture survivor and the justice system.
- The lawyer may have the responsibility of representing and advising the individual through the many procedures within the judicial process.
- The lawyer's role will often begin at the early stage when the torture survivor is in custody, and will continue until redress has been achieved
- A primary concern for the lawyer will be to establish the facts of the case. This will involve collecting all available details of times and places of the alleged torture, as well as the identification of those responsible
- The evidence collected by the lawyer will include statements of the individual and possible witnesses, and medical evidence obtained with the help of the health professional.

4.2 (c) Role of the NGO member in the team

Experience over the past decades has shown that human rights NGOs vary in mandate, focus, and methods, but some can contribute in important ways to the documentation of torture and subsequent legal action:

- They can assist individuals to gain advice, services and treatment, from the legal and medical professions, through lawyers and health professionals who are part of the NGO or by referral to others
- NGOs are often best placed to handle the case of the individual in the international arena, for example by assisting and advising in making complaints to international courts and other mechanisms
- The information held by the NGO on other similar cases and the research conducted on torture and other ill-treatment domestically and internationally, can provide valuable support to the case of the individual. Their knowledge of local circumstances can be very important. In certain cases it may be possible to combine a number of cases into joint complaints and petitions
- NGOs often have the expertise for any necessary work to be done through public advocacy or with the media.
- NGOs can assist in the prevention of abuse, for example by circulating information about those who have been recently arrested.

Although the circumstances vary considerably between countries, generally it is better for an NGO to be open about its activities in helping survivors of torture and to develop links with relevant regional and international bodies as this makes it easier to seek protection from intimidation by the national authorities.

4.3 Documenting the allegations

4.3 (a) The aim of medical documentation

Medical documentation plays a major role in all the general aims of investigation into torture allegations that have been described at the start of this chapter. Medical documentation fits into those aims through the following means:

1. Producing a contemporaneous record (a record as close in time as possible to the event) of signs and symptoms of ill-treatment when an individual presents to any health professional for treatment after the event – the examining health professional may not be called upon to produce a report, but in the future an expert may be asked to use this record to form an opinion of events at the time
2. Providing detailed understanding of the case so that the person can be referred for the appropriate treatment and rehabilitation in a specialized centre or by other specialists
3. The production of a medico-legal report for submission to a judicial or administrative body:
   i) for judicial enquiries or court cases aimed at the prosecution of perpetrators
   ii) for a judicial process which decides on the responsibility of the state
   iii) for a judicial process which decides upon compensation/reparations for survivors

iv) in individual cases where a medico-legal report may be used as part of a court application to end on-going abuse while the person is still in detention

v) for the case of asylum seekers when medical evidence may be used as part of the evidence (e.g. in hearings) to show a history of ill-treatment in another country and the physical and psychological consequences thereof.

4. The documentation of patterns of widespread abuse. Courts, NGOs, and inter-governmental mechanisms, can all have need for knowledge of the existence of widespread abuse. Assessment of the prevalence of torture and other ill-treatment, relies upon well-documented individual allegations

5. The production of supporting material during visits to places of detention. Medical documentation may not necessarily lead to the production of a medico-legal report on specific cases, but the medical findings can be used more generally to support allegations of conditions and treatment amounting to torture or other ill-treatment.

4.3 (b) Types of evidence

Medical evidence is one of many types of substantiation given to allegations of torture and other ill-treatment, and will often be used in conjunction with other forms of evidence. These will commonly include:

- The individual's statement N Witness statements
- Other forms of third party evidence, such as the testimony of a forensic scientist or other expert
- Objective evidence of a widespread occurrence of torture in the circumstances referred to
- Anything else which can help to support and prove an allegation.

4.3 (c) Medical evidence

Medical evidence is a very important type of evidence as it can add strong support to witness testimony. It is rare for medical evidence to be conclusive (prove with certainty that torture occurred) because:

- Many forms of torture leave very few traces, and even fewer leave long-term physical signs that they ever occurred
- Injuries or marks which are alleged to have resulted from torture cannot always be distinguished with a high degree of certainty from the effects of other causes.

What medical evidence can do is demonstrate that injuries or other clinical findings recorded in the alleged survivor are consistent with (could have been caused by) the torture described (see section 4.6). Where there is a combination of physical and psychological evidence compatible with an allegation, this will strengthen the overall value of the medical evidence.

When obtaining medical evidence, it is important to be aware of the difference between therapeutic (treating a patient's symptoms) and forensic (legal) medicine. The objective of forensic medicine is to assist the courts and other appropriate authorities in medico-legal matters, for example, by establishing the causes and origins of injuries. Sometimes both therapeutic and forensic functions are carried out by the same health professionals but, where possible, they should be separated to avoid a possible conflict between the two roles. Failing that, the possible conflict should be recognized and discussed by the report writer.

Case of Selmouni v France
(Application No. 25803/94)
Judgement
Strasbourg
28 July 1999

The European Court of Human Rights, in reaching its conclusion, cited the medical findings in an earlier judgement of the Versailles Court of Appeal. The reliance on medical findings demonstrates the significance of thorough medical documentation as a tool in establishing allegations of ill-treatment.

'***As to the medical findings***
The accusations made by the civil parties are supported by unequivocal medical findings. In the first place, as regards Selmouni, the expert Professor Garnier noted in his report of 5 May 1998 that all the doctors who had examined him while he was in police custody had found lesions of traumatic origin on the left arm, in the left orbital region, on the scalp and on the back. On 29 November 1991 further lesions were seen on the lower limbs. He added that during his examination on 7 December 1991 he had again found lesions that had been described earlier and that he found others on the buttocks and on the right ankle.

The extent of the injuries on Selmouni's person increased as the uninterrupted police custody continued.

The bruising to the left eyelid, the thin linear scar one centimetre long continuing the line of the left eyebrow, the left and right sub-orbital haematomas found on 29 November 1991 by Dr Edery, and then described on 2 December 1991 by Dr Nicot as being "round the eyes", are consistent with the punching mentioned by Selmouni.

The various haematomas found on the thorax, the left and right sides and the abdomen are consistent with the punching and kicking in his statement of 7 December 1991.

The pain in the scalp and the headaches mentioned by Drs Aoustin and Edery are likewise of a kind to support Selmouni's statements, according to which his hair was pulled and he was repeatedly tapped on the head with an instrument which could have been a baseball bat.

The haematomas found on the buttocks and the thighs could only have come from blows from a blunt instrument. Similarly, the lesions apparent on the legs, ankles and feet are consistent with the blows or crushing that Selmouni complained of.

It follows from the foregoing that the objective injuries, as recorded in successive examinations, match the blows described by Selmouni.'

4.4 Gathering of evidence

The medical evidence will be used in combination with the other types of evidence mentioned above. Detailed guidelines on gathering medical evidence, including the interviewing of victims, physical and psychological examinations, and writing medical reports, are all the focus of the following chapters.

Health professionals engaged in the documentation and investigation of torture ought also, however, to be aware of certain non-medical aspects of evidence gathering. In ideal circumstances, there will be a number of people responsible for collection of evidence, and other members of the team, particularly the lawyers or NGO professionals, will coordinate the collection and ensure that all requisite details have been gathered. However, in some circumstances not all members of the team will have access to the victim, and it is therefore crucial that each member is aware of the necessary details essential for the substantiation of alleged abuse. The level of proof and detail may vary depending on the purpose of documentation: for example, a criminal trial requires higher standards of proof than a civil hearing or administrative procedures determining potential risk in case of deportation. If the health professional is the only person with access to the victim or other source of information, it is vital that he or she attempts to collect, or ensures that others collect, key information, beyond the purely medical evidence.

4.4 (a) Essential information

In all cases, in addition to the medical evidence and information, the following non-medical details should be viewed as useful and often crucial information regardless of the purpose of documentation:

Identity of the victim. This should include full name, gender, age, occupation, and address. Date of birth is a useful identifier when the name is a common one; often the year is known although it might not correspond to the age given. Additional useful information would be a description of appearance, a photograph, and any relevant records that may exist on the individual, such as medical files from the time before the alleged abuse.

Identity of the perpetrators. This might include the identification of a particular individual or individuals. However, to establish responsibility of the state for a violation, it might be enough to show the connection with the state. Relevant information would detail whether they were members of a specific security force such as police or military and, if possible, their names and rank. If unsure, then a description of uniforms, vehicles, weapons or any identifying characteristics will assist in the determination. Note, for legal and human rights reasons, great care should be taken in making allegations that particular individuals have been involved in torture. These are, after all, allegations of serious criminality.

Description of how the individual came into the hands of the perpetrators. This should include whether the person was officially arrested, what reason was given for taking the person into custody, the time and date this took place, and whether there was use of violence or restraints.

Description of the location where the abuse took place. This may have been a prison, a police detention facility, a military installation, or any other institution or location, even an outdoor space.

Additional useful information would be a description of the conditions in which the individual was held, including size, content of the room, lighting, hygiene, presence of others, and access to lawyers, visitors, and medical care.

Description of the form of abuse. The crucial questions are: Where did it occur? What happened? When? By whom? How often? How long did it last? And what effects did it have on the victim immediately and later? There should be a detailed description of exactly what occurred, and how frequently. Presence of anyone else in the room during the interview, whether detainees, security personnel or others, should be mentioned. Any instruments used should be noted. What were the immediate and long-term effects of the abuse? If the victim received medical attention, or requested it and the request was denied, directly before, during, or after the abuse, this should all be detailed.

Possible witnesses. Were there others present at the time of the abuse. Who were they? What was their role (for example, other detainees)? Did others see the individual immediately after the ill-treatment (for example, cellmates or prison medical staff)?

4.4 (b) Quality of information

The primary goal of documenting allegations of human rights violations is to create an accurate, reliable and precise record of events. The uses to which this record may be put are varied, but all rely on the quality of the record which has been established. Factors which contribute to the quality of information are:

The source of the information. Was the information obtained directly from the victim? The further away from the victim or incident the information comes, the less reliable it is likely to be.

The level of detail. Is the allegation very detailed? Are there unexplained gaps in the account? The more detail obtained, the better, because it helps others to understand what happened, and it also helps to prevent allegations of fabrication. Psychological and/or organic explanations for gaps should be kept in mind [see section 6.2 (c)].

The absence or presence of contradictions. Minor inconsistencies are common and should not affect the overall quality of the information, but major inconsistencies or contradictions should prompt seeking further clarification of the information [see section 6.2 (c)].

The absence or presence of elements which supp ort (corroborate) or disprove the allegation. Are there witness statements, medical certificates or any other supporting information? The more supporting documentation that is provided, the more likely it is that the allegation will be found credible, but its absence is not evidence that the ill-treatment did not occur.

The extent to which the information demonstrates a pattern. Is the allegation one of a number alleging similar facts? Where there is evidence of a practice there may be a greater presumption that the information is true.

The age of the information. Is the information very recent? Does it relate to facts which occurred several years previously? The fresher the information, the easier it is to investigate or verify the facts

alleged.

4.4 (c) Comparing records

Different members of the team might have notes or memories that emphasize different aspects of the individual's account. This is particularly true when the team comprises members with different professional backgrounds. Interviews should be reviewed and notes compared before one member is delegated to write up the relevant interview. All notes should be retained.

As the team comes together, it may be able to identify patterns of a general nature, especially if several teams are working together, and not every team member is aware of the information gathered by the others. Evidence that appeared incomprehensible or implausible might be clarified by the understanding of evidence gathered by other team members or teams. They can then discuss how to take the work forward, for example by anonymising data and analyzing them in groups.

4.5 Compiling medical documentation

4.5 (a) Report writing

Not all medical evaluations will require the writing of a report. Where a health professional comes across a case of torture in their regular practice, a note made in the medical records may suffice. The note in the records may then be interpreted by an independent expert who may form an opinion based solely upon these records. However, the examining health professional may be asked to provide a medical report based upon their own findings, or a summary of a number of similar cases. The type of report they produce is dependent in part on the use to which the report will be put. For example, the report may be used in an application for asylum or in the prosecution of perpetrators. Such reports are of a medico-legal nature since they form part of medical evidence that is put before an administrative or judicial body. In all cases, the duty to the court or other body must be acknowledged.

A health professional who is asked to examine an alleged survivor of torture in order to provide an independent evaluation for a judicial or quasi-judicial body is acting in a forensic capacity rather than in a therapeutic capacity. The health professional's duty is to the court to provide an independent opinion on the allegations together with any corroborating medical evidence. Thus, in the absence of an acute medical emergency during the examination, the health professional is not acting in a therapeutic capacity. This does not, however, preclude him or her from referring the individual for further clinical assessment and treatment to the appropriate specialist. The section below refers to cases where the health professional has been instructed to produce a medico-legal report.

4.5 (b) Destination

Medical documentation can be of value in a number of arenas, including:

1. Identifying the need for further care and treatment
2. The prosecution in national or international courts of perpetrators alleged to be responsible for

torture

3. Claims for reparation
4. Challenging the credibility of statements extracted by torture
5. Identifying national and regional practices of torture in human rights investigations
6. Support of allegations of torture in asylum applications.

4.5 (c) Content

Further guidance on the approach to the taking of the history, the examination and the compilation of the final report is detailed in The Istanbul Protocol, which should be viewed as the 'gold standard' for the documentation of torture, and from which this section is adapted.

The report should be based on the health professional's overall opinion made at the end of the interview and on further consideration during follow-up (see section 4.6). Generally the final report has a number of parts:

- The account of the event(s) as described by the individual. As described above, this should detail events during arrest and conditions of any detention (e.g. prolonged solitary confinement) since these conditions in themselves may produce physical and psychological sequelae. The account should further detail specific events and methods of torture, both physical and psychological, during actual interrogation. If there are internal inconsistencies in the narrative, or if it contradicts testimony given elsewhere (for example to a legal adviser), this must be explained
- A description by the individual of his or her physical and psychological symptoms and signs at the time of alleged ill-treatment, and an account of how these symptoms evolved with or without medical treatment
- A description of the individual's physical and mental health at the time of the interview(s) and, if he or she has been seen over a period of time, how they have changed with treatment and as a consequence of concurrent events
- A note of any medical treatment in detention, or any treatment that was requested but denied
- An account of the physical and psychological findings from the interview(s). This should include the demeanour at different times of the process (including any contact before and after the interview(s)), the results of any psychological assessments, a detailed account of the physical examination, and the results of any investigations performed
- The professional opinion on the likely causes of these findings, discussing other relevant possible causes of those lesions attributed to torture. There should also be a summary, and the conclusions of the overall examination. (Note: it is better to separate the findings and the opinion into separate sections, as this makes it clear to any reader which is

which.)

When gathering information to prepare a report, it is important not to over-interpret the findings and so diminish the quality of the evidence. That is to say, however sympathetic the health professional may be to the individual, the report or certificate should not say more than can be supported by the evidence and the level of competence of the report writer to interpret it, or the case might be undermined.

Depending on the intended forum, a summary of the findings of other team members could also be needed, or each might need to provide a separate report. There may also be the sections required by the relevant court, such as the reason for the interview, the background documents read beforehand, a detailed CV of the author and a statement of the duty to the court. Relevant professional qualifications should be listed. The report is an expert document, and the writer should identify the level of expertise, for example as a general health professional, or as someone with forensic expertise but not with survivors of torture.

4.5 (d) Inconsistencies

When anyone gives more than one account of his or her experiences, there are inevitably points that are inconsistent with each other. Thus the interviewer should avoid topics that are not directly relevant to the report. Within an interview, it is essential for the interviewer to clarify these points or explain the discrepancies [see section 6.2 (c)].

Sometimes the account may conflict with one given previously, for example, to a legal adviser or other non-medical interviewer. The medico-legal report should identify these inconsistencies and, if they are relevant, explain them. The report is a legal record of the interviews and should not be amended to minimize these inconsistencies if this reduces the report's accuracy.

4.5 (e) Glossary

Many words have a specific meaning in medico-legal reports that differ from their use in everyday speech, such as 'history' or 'laceration'. It may be necessary to append a glossary to the report, so that readers do not misinterpret some of the words by applying their everyday meaning.

4.6 Opinion

Any health professional should be able to document injuries and other physical and psychological findings. When trying to assist the courts or other judicial or administrative bodies, where possible there should also be an opinion on the consistency between these findings and the allegation of ill-treatment. This section is intended to give basic guidance in this process. However, it is important that the health professional does not exceed his or her capabilities. A well-documented account of findings can be very useful to an expert where necessary.

4.6 (a) Individual lesions

For each individual lesion, the health professional should determine whether it is congenital, the consequence of a disease process, degenerative or traumatic. For each lesion attributed to trauma

and for the overall pattern of lesions the report should indicate the degree of consistency between it and the attribution given by the individual.

It is more important to focus on lesions that are distinctive rather than on their number or size. A few wounds that are highly consistent with an allegation of torture are more significant medico-legally than those that are non-specific. If there are other possible causes for wounds, these should normally be documented. For example, a sportsperson may have many scars on his or her legs, and it is impossible to say which were caused by contact sports and which, if any, were caused by being kicked by soldiers in detention. A stab wound on the trunk, however, is not going to have been caused by sporting activities.

If a survivor of torture has many overt scars on his or her body, this could well be because the security services in the country in which he or she was tortured enjoy impunity. Where judges are encouraged to take seriously allegations that confessions were extracted under torture, interrogators are likely to be careful not to leave identifiable marks, and might not assault a detainee for several days before a court appearance in order to let bruises fade.

Some survivors of torture have no scars or other physical signs. This should be documented and it must be emphasized that the absence of physical findings does not, in itself, invalidate a person's account of torture.

Recommended terms to describe lesions attributed to torture

Not consistent: The lesion could not have been caused by the trauma described. (If this term is used in a medico-legal report, the writer must explain why the individual's account is considered to be credible, despite this inconsistency (see also section 4.6.3 on truth and fabrication).)

Consistent with: The lesion could have been caused by the trauma described, but it is non-specific and there are common alternative possible causes. (Most scars are non-specific and it is important not to over-interpret them. Only if the overall number or distribution of scars is significant can much weight be placed on them in the final report.)

Highly consistent: The lesion could have been caused by the trauma described and there are few other possible causes. (Depending on the level of proof required by the court, such scars may be sufficient to corroborate the individual's testimony.)

Typical of: This phrase is used for lesions that are 'highly consistent' with the attribution and additionally the appearance is one that is usually found with this type of trauma (for example, cigarette burns).

Diagnostic of: This appearance could not have been caused in any way other than that described. (This is strongly supportive of the individual's account, but does not, by itself, confirm that torture has occurred because the status of the perpetrator and the purpose of the assault are also relevant.)

It is the overall evaluation of all lesions that is important in assessing the allegation, rather than the consistency of each lesion with a particular form of torture.

BOX 1 (adapted from The Istanbul Protocol, section 8.2)

Distinctive scars should be described accurately. For example: 'There is a 3 cm laceration, 1 cm wide at the widest, across the back of the left hand.' Very small wounds need not be individually documented unless they are relevant to the allegation.

Sometimes a patient will say that an injury was caused by torture when clearly that is not the case. This may be because of a misunderstanding. For example, the person might not be aware of scars across the upper back from childhood chickenpox. When these are pointed out by a health professional, the patient might say they are the result of torture, believing all scars were a consequence of torture. Another patient may be claiming deliberately that a wound was caused by torture, knowing this is not the case. Perhaps he or she has no scarring from torture but thinks he or she will not be believed without some physical evidence. In both these situations the health professional has a dilemma. A false opinion supporting the patient's attribution must never be given. The alternative is to document the lesion, the patient's attribution and the heath professional's opinion, even though this might undermine the credibility of the patient. However, if the health professional words the report sensitively and emphasizes other aspects of the examination that support the allegation of torture, this should minimize the negative impact. However, the health professional should not lose sight of the need for objectivity.

It is sometimes suggested that scars and other lesions might be self-inflicted. True self-inflicted wounds are of two main types. One is where a person is deliberately harming him- or herself to support a false claim of assault. Such wounds are generally superficial and within easy reach of the dominant hand. Very rarely an accomplice might be asked to cause a wound in a place the person cannot reach, such as in the middle of the back. The other form of self-harm is where the person has a mental illness. Such wounds can be complex, but generally the underlying mental health problem can be identified during the interview. Occasionally a person will have wounds from an unsuccessful suicide attempt in detention, perhaps a desperate response to an intolerable situation. Although the person might be unwilling initially to disclose the true cause of the wounds, with sensitive questioning he or she will normally say what happened.

4.6 (b) Psychiatric assessment

When writing reports, health professionals should comment on the emotional state of the person during the interview, symptoms, history of detention and torture, and personal and family history prior to torture. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, as well as patterns of psychological functioning should be noted. Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, loss of home, family, social status, as well as unemployment should be described. If a formal psychiatric diagnosis is given, the reasons should be explained [see also sections 6 and 6.3 (a)].

4.6 (c) Overall picture

At the end, the health professional must give his or her opinion of the totality of his or her findings, both physical and mental. He or she can say how strongly the findings support or do not support the

allegations. The report may have corroborative value when it is added to the other evidence in the case.

All the available information should then be brought together in order to prepare the final report, including:

- Copies of any previous court decisions about the individual
- Correspondence from other health professionals to whom the patient has been referred
- Background information about the situation in the country to which the allegations of torture relate (e.g. from the UNHCR (United Nations High Commissioner for Refugees) or Amnesty International)
- The account of the event(s) as described by the individual
- Notes on the individual's description of his or her physical and mental health
- Records of the psychological and physical findings from the interview(s)
- The results of any clinical investigations
- Recommendations for further treatment.

This will then allow the health professional to give an opinion of the likelihood of the patient having been tortured in the way that he or she described, to the standard of proof required by the appropriate forum. Ultimately, it is for the court to decide whether the individual is credible, but health professionals must not ignore the issue. Credibility is not an all-or-nothing concept - there is a continuum between the absolute truth and the complete fabrication of events, with at least three points in-between: a) A mixture of falsehood and truth, e.g. a fabricated history of a recent detention added to a genuine one in the past b) Conscious or subconscious exaggeration - saying that the ill-treatment was more frequent and more severe than actually happened c) Genuine errors arising from mistakes and misunderstandings.

The health professional should then make a final statement summarizing the opinion.

SOURCE: Michael Peel and Noam Lubell with Jonathan Beynon, **Medical Investigation and Documentation of Torture: A Handbook for Health Professionals**, Human Rights Centre, University of Essex, 2005, with modification.
Available at http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

V. INTERVIEWING

5.1 Introduction

The documentation of torture and other ill-treatment depends on the gathering of detailed and accurate information from the individual on the circumstances of the event, including details of any arrest, detention, conditions of detention and specific treatment while under interrogation. The degree of detail gathered depends on several factors, such as the aim of the interview/examination (producing a note in a medical record of incidental findings during a routine medical visit, versus being asked to provide a medical report for a judicial body), the location and circumstances of the interview (for example in a health clinic, in a police station or prison, or in a rehabilitation centre for survivors of torture) and the degree of access to the individual and amount of time available. This being said, the principles on interviewing set out in this chapter can be adapted and applied to the various circumstances in which a survivor of torture or other ill-treatment may be encountered.

As with most clinical practice the interview or 'history' is the key to this process. Torture usually involves both physical and psychological components, during the ill-treatment and the arrest and detention, so the interview must address both the physical and psychological components of the experiences and events.

There should be a detailed description of the ill-treatment taken as close in time to the event as possible. If there has been an arrest or any period of detention, the description should include details of the conditions of detention, especially the nature of the accommodation (including size, shape, space, natural and artificial light, temperature, ventilation, and hygiene), the daily routine, and access to water, food, sanitation, health care and the open air. All of these elements of arrest and detention can produce physical and psychological manifestations

(e.g. malnutrition, vector-borne disease, anxiety etc). The interviewer should then take a detailed description of specific methods of ill-treatment employed during periods of questioning, interrogation or indeed at any time while they are in the control of the authority. It cannot be over-emphasised that it is not sufficient to document only physical ill-treatment and any resulting injuries or scars. Psychological methods must also be accurately noted since these will often produce both psychological reactions and physical symptoms. For documentation of the psychological sequelae the interviewer must take a detailed psychological history and conduct a mental state examination [see section 6.3 (a)]. For physical sequelae the interview should be followed by a thorough physical examination and written description of the findings. The written findings can be supplemented by annotated diagrams of the body and, where possible, photographs (see section 6.6).

An interviewer will make notes of the interview, and may use other recording devices. The reasons for this should be explained to the interviewee who should be reassured as to how the notes and other records will be used and asked for consent [see also section 3.2 (h)]. The way in which any records of such interviews are stored can be important in protecting the security of the interviewer and the interviewee [see also section 3.2 (i)].

In many countries where torture is prevalent, the police have been known to raid clinics and search or confiscate medical records. In order to protect patients, therefore, in such conditions records should have no obvious identifying information on any document inside (such as initials or date of birth), and the files themselves being numbered with a register kept in a secure place elsewhere. Patients can be given cards with the identifying number so that treatment can be continued even if the register is not available. In some circumstances it may be necessary to hold records at a different location or even in a third country to ensure their security.

If information about an individual needs to be transmitted to another body [see section 2.8 (b)], fax transmission is generally safer than e-mail as a copy of the latter may be stored on the sending computer or held on the server of the internet service provider. In some countries the authorities routinely screen all outgoing messages.

5.2 Vulnerability of witnesses

5.2 (a) Protecting survivors and witnesses

In many circumstances, survivors and witnesses need to be protected from those they are accusing. Promises must not be made, for example, to provide security for the witness or for relatives who might be at risk, unless the interviewer is certain that they can be fulfilled. Witnesses might believe that international organizations or others investigating allegations of torture have more power to protect them than is the case. It is part of the informed consent process that individuals are aware of all the issues before they agree for a health professional to make a formal report [see section 3.2 (h)].

5.2 (b) Vulnerability

As they are survivors and witnesses of torture, it is inevitable that many interviewees will be vulnerable in the psychological sense. They may also be vulnerable in other senses, for example they or their family members might be at risk of reprisals from the perpetrator.

This means that the survivor or witness who is vulnerable needs to be interviewed especially sensitively but thoroughly. Security, reassurance and tact are very important.

It can be therapeutic for a survivor of torture to give an account of his or her experiences in a supportive, trusting environment. This does not mean that everything must be taken at face value. Questions should be asked to check and clarify points which appear unclear, inconsistent or contradictory; this should be done in a way which does not undermine the trusting relationship necessary for effective interviewing, and with a view to providing as precise a record as possible, so that any documentation is accurate.

It is essential that the interviewee is able to consider him- or herself to be in control of the interview since a central element to torture is the enforced loss of control and autonomy of the person. He or she should feel able to answer only those questions with which he or she feels comfortable at the beginning and postpone others until later. Some witnesses may want to delay discussing more sensitive topics, perhaps to a later interview if that is

possible, by which time they feel comfortable with the interviewer. Others may have been worrying about the interview and may want to start discussing the details of being tortured early in the interview. Attention must be paid to the physical needs of the interviewee - there should be water available to drink, and breaks can be taken at any time.

5.2 (c) Interviewing children

Children have the rights to have their consent and confidentiality respected. Except in emergency they should not be given medical treatment without a parent or guardian present. Similarly, a detailed account of the cause of injuries should only be taken from a child in the presence of a parent or guardian or, if they are not available, someone else representing the child's best interests.

Older children may be tortured to suppress political activity. They should be treated in the same way as young adults, and the approach needs to be very sympathetic. Torture of younger children is generally performed to put pressure on parents. Where possible, the family should be treated together and the child's injuries should be documented and managed by paediatric specialists.

A child in particular needs to be in an environment in which he or she feels comfortable before being willing to disclose sensitive information. In discussing traumatic events, a child may prefer to draw a picture and then to explain it. Children's attention spans can be quite short, so it may be necessary to break the interview frequently.

5.3 The environment of the interview

5.3 (a) Physical environment

In many situations it is not possible to control the environment of the interview (for example in police stations and prisons), and the interviewer will have to make the best of less than ideal conditions. However, as stated above, the basic principles on interviewing should be adapted and applied as far as possible to the different contexts. Where health professionals and other interviewers are using their own premises, the physical environment can be controlled. Where possible, it is essential to avoid anything that might remind the interviewee of being interrogated in case this triggers psychological symptoms [see section 5.2 (b)]. Such sounds as footsteps, keys and doors should be minimized. Rooms should have a comfortable temperature and be well lit, Most survivors of torture are not distressed by a clinical environment, but some individuals may have been exposed to medical participation in their ill-treatment and so may be wary of the medical setting and personnel.

Where possible, the interviewer should meet the individual wherever the individual is waiting for the interview. Not only is this polite, but it allows the interviewer to notice the individual's demeanour at rest, how he or she gets out of the chair and walks to the interview room. Normally the individual should sit nearer the door of the interview room so that he or she does not feel trapped, although for personal safety reasons it is better if the exit for the health professional is also not obstructed.

5.3 (b) Gender considerations

Female interviewees should, if at all possible, be seen by female interviewers, at least in the first

instance. If one is needed, the interpreter should be female as well (see section 5.5). In many cultures, women are unwilling to disclose details of ill-treatment in front of a man, so the account will be incomplete. This will be particularly true if she has been raped or sexually assaulted (see section 6.4). One approach that may be considered is to ask the woman if, in addition to the health staff, she would like a friend or relative present for support. Paradoxically the presence of a friend or relative may in fact inhibit the interviewee from revealing more intimate or traumatic events, especially of a sexual nature, and thus the question should preferably be asked when the third person is not present. In clinical interviews, it will also be necessary for the patient to have her body examined by the health professional, and most women prefer that this is not done by a man (see mention of chaperones in [section 6.2.(a)] . This inherent reluctance is considerably increased in survivors of torture as it is likely that the torturers were male.

For male survivors, particularly those who have been sexually assaulted in detention, the situation can be more complex. In general they should be seen by a male interviewer and interpreter, but some men prefer to talk about sexual abuse in front of women. In some cultures and societies this may be due to feelings of shame or embarrassment in describing sexual abuse to another man, or it may be that describing such abuse to men, particularly of the same ethnic background as the torturer, may remind them too much of their experiences.

Following the above, it is clear that the staff team should ideally include health professionals and interpreters from both genders, allowing the individual to choose who they would be most comfortable with. In many settings, such as large organizations and hospitals in big cities, this should be the standard and not deviated from. In some circumstances, however, such as small teams engaged in field missions, it might not always be possible. In these cases, particularly with female interviewees, if the health professional is not of the same gender as the individual, there should be an interpreter present (when one is used) or other team member of the same gender, or another person chosen by the interviewee, thereby easing the discomfort. While vital evidence and information should not be missed due to not having a same gender interviewer, the individual must always consent to being interviewed by the health professional (and to others who may be present), and any gender imbalance or discomfort with the situation should be entered in the notes.

5.3 (c) Cultural and religious awareness

Cultural and religious awareness is of utmost importance. The health professional should make sure to conduct him or herself in a manner that does not offend cultural or religious sensibilities, and have an understanding of how culture or religion may be affecting the behaviour or responses of the interviewee. A lack of such awareness risks alienating the individual and/or causing them to feel uneasy, leading to a less effective interview.

5.3 (d) Time and space

The pace of the interview must be dictated by the individual. Even if there is limited time for the interview (such as in a police station or prison), the interviewee should not feel rushed. It is better to focus on a few specific points than to try to cover too much ground in too little time. If there are many

interviewees to be seen over several days, each should be seen once or twice for a substantial period of time, rather than several shorter sessions. However, as a rule, interviews should not be scheduled to last more than about one and a half hours (although such a period is a luxury in many schedules), because after this time the interviewer, the interviewee and (if present) the interpreter, all become tired. It may be necessary to allow a session to overrun, for example, if the individual has almost completed the account when the set time is up. In a clinical setting, the interviewer should allow enough time between appointments to allow for this and for sufficient time to write up his or her notes. It is good practice to write up the notes of each interview at the end of that session, as various aspects of the individuals' accounts may become confused if the interviewer attempts to write up all the interviews in a later single session, and details may be forgotten.

5.4 The interview itself

At the beginning of the interview, the interviewer and, if present, interpreter, must introduce themselves and explain the purpose of the interview and about independence and confidentiality. There are three parts to the interview and it is for the interviewer to decide on the order in which these are raised, depending on the way the interviewee responds. It is essential to remember that the well-being of the individual is more important than the information to be gathered. He or she may want to discuss domestic matters before discussing details of ill-treatment, in order to settle and learn to trust the interviewer.

The three parts are:

- The present physical and psychological state, which is what an interviewee would be anticipating discussing with a health professional.
- A chronological account of ill-treatment starting with the first episode of conflict with the authorities, which may be what the interviewee has prepared him- or herself psychologically to discuss.
- The past, personal, family and social history of the interviewee, which forms the context of the experience(s) of ill-treatment.

Some survivors of torture or other ill-treatment who have been interviewed before about their experiences might have developed a summary that they can recite without undue distress. For example: 'I was arrested, held for five days, beaten and tortured.' It is necessary to acknowledge this account and then ask for substantial details of the experience. Detail about the circumstances of arrest and detention help to demonstrate the authenticity of the history and may provide specific information of use to prosecutors.

Some survivors of torture or other ill-treatment have had little or no education and this can lead to perceived contradictions or require alternative approaches to information gathering. For example, an individual who is not numerate may not be able to give accurate responses to questions about how many soldiers arrested him, or for how many days he was detained. If asked the same numerical question on different occasions, he may give very different answers. It is better to frame questions in more general terms (e.g. 'were there a few or many of them?'). The same is true of dates, as many

rural societies do not use calendars routinely. It may be better to ask, for example, 'What was the season?' rather than 'What was the month?'

5.4 (a) Types of questions

Generally, open-ended questions should be used, for example: 'Can you tell me what happened?' or 'Tell me more about that.' The individual should be allowed to tell his or her story with as few interruptions as possible. Further details can be elicited with appropriate follow-up questions, such as: 'How big was the cell?', 'Was there any lighting?' and 'How could you go to the toilet?' Asking too many questions too quickly might confuse the individual, or even remind him or her of being interrogated.

Leading questions are avoided wherever possible, because individuals may answer with what they think the health professional wants to hear. This is especially important when interviewing for medico-legal purposes, where the testimony may be challenged in court. Closed questions, which provide the interviewee with a limited number of options and, particularly, list questions, can cause confusion in the individual and might create unnecessary inconsistencies. For example, an individual might be asked, 'Were you arrested by the police or the army?' limiting the answer to a choice between the two. If he or she was arrested by a special task force of soldiers and policemen working together, it would be difficult to give an accurate answer without appearing to contradict the health professional. This could in turn create inconsistencies between statements [see section 4.5 (d)].

5.4 (b) Cognitive techniques

Psychological research has shown that the ability to recall important incidents can be enhanced by using some basic cognitive techniques. Having established rapport with the individual, he or she should be allowed to give a free narrative about the events. The interviewer should allow the individual, as much as possible, the time to describe what happened in his or her own words. Clarification of points is permissible but not direct questioning which might break the individual's recall. Only after the individual has finished his or her narrative should direct questions be asked to clarify points. The survivor of torture should know that it is acceptable to say: 'I don't understand the question,' or 'I don't know the answer.' When closing the interview the next stages in the process should be agreed with the individual.

The quality of the information gained can be improved by some specific techniques. Firstly, in a clinical setting in which time allows it, the individual should be told to describe everything surrounding the time of ill-treatment (for instance describing the events and process of being taken into detention), even if it doesn't appear directly relevant to him or her. This might relate to events that could be more important than the individual realizes. Secondly, as he or she relates them, this can bring other events that are more relevant into his or her mind. It helps if he or she is encouraged to recall the context in which the events happened.

Having encouraged the interviewee to describe the events in a free narrative, in chronological order, the interviewer can seek more detail by asking questions in a different order. For example, by

reversing the order: 'You were telling me ..., what happened just before that?'

Another tool is changing the perspective, which means trying to describe the events from another point of view, for example if the interviewee is sufficiently well-educated the interviewer could ask: 'How would a tailor describe what the man was wearing?' or 'When you were arrested at the demonstration, what would a spectator have seen?'

It is important to remember that different cultures have different concepts of what is normal behaviour in an interview. In some societies it is considered polite not to look directly into the eyes of someone in a position of relative authority (such as an interviewer), whereas in other cultures such behaviour is considered to be a sign of dishonesty. People from some cultures find constant hand movements a normal part of communication, whereas those from others find them distracting. Personal space varies between and within cultures, and what might be normal between colleagues could feel too close in an interview setting. This could make the individual feel anxious, and behave in a way that the interviewer perceives as uncooperative.

5.4 (c) Summarizing and clarifying

During the interview, it is often helpful to clarify points, in order to ensure that the information is accurate. For example: 'When you say that you were suspended by your arms, in what position were they?' Alternatively the individual can be asked to recreate the position, but it should be borne in mind that doing so could provoke uncomfortable feelings or other reactions in the individual.

At the end of each session, it generally helps to summarize the key points, to ensure that they are clear. This sometimes has the additional benefit of getting the individual to remember details that add to the narrative.

In the event that a medical report will be produced it is good practice, where circumstances allow, to see the individual again once the report has been completed, to read through to him or her the history/narrative within the report for accuracy and consistency. This also provides an opportunity to follow up any clinical problems that were identified in the interview.

5.5 Working with interpreters

Good interpreters, particularly those from the same background as the individual, are able not only to interpret the words, but also to identify and explain relevant cultural, historical and social factors as well as linguistic idioms to the interviewer. Beware, however, of over-reliance on interpreters, as they are not experts in areas outside their own field.

Interpreters are an important part of the inquiry team. They need to be trained to work with survivors of torture and other ill-treatment even if they have considerable experience of interpreting in other contexts. Most professional interpreters have their own code of ethics. If not, they must be advised

that what they hear and interpret in interviews is ***strictly confidential.***

Professionals working with interpreters need to remind themselves that, if they do not share a language with the individual, the quality of the interpreter used will impact on all aspects of their interview, examination and report.

5.5 (a) Second and third languages

In situations where the health professional is seeing the individual in their routine practice, they will usually speak the same language. In situations where there are several ethnic groups within a country, there may be language barriers within the population. Sometimes the one will speak some of the other's language, or they may share a third language. The danger is that if one person's command of this second or third language is weak, this may lead to inaccuracies and inconsistencies in the report. There may also be difficulties associated with interpreters of a different ethnicity or from a different region from that of the individual. The accent and vocabulary might differ.

5.5 (b) Gender and age of interpreters

In many cases, it is necessary to use an interpreter for some, or all, of the interview. The issues of gender discussed above [see section 5.3 (b)] may be even more important in this situation as the interviewee may relate more to the interpreter than to the interviewer. Some individuals are less concerned about the gender of the interviewer than they are about that of the interpreter. Age may also be relevant. A young male individual may be able to discuss sexual torture with an older woman to whom he may relate as to an aunt, but not to a woman of his own age. Similarly, a young female individual may find an older man easier to talk to than one who is of a similar age to her torturer. Bear in mind, however, for women, having a female interviewer and interpreter is the best practice [see section 5.3 (b)].

5.5 (c) Local and international interpreters

When an international team makes a visit to a country it might include interpreters, or it may choose to employ local interpreters. There are two issues to keep in mind in such cases. Firstly it must be made clear to the local interpreter that he or she may be putting him- or herself into danger by working with visiting interviewers when documenting torture. Secondly, the individual may not trust a local interpreter and so not give a complete account of what happened.

5.5 (d) Using an interpreter

Interviewers should remember to talk to the individual and to keep eye contact with him or her even though there is a natural tendency to speak to the interpreter. It helps to pose questions directly to the first person, for example: 'What did you do then?' rather than indirectly through the interpreter, for

example: 'Ask him what happened next.' Observing body language, gestures and facial expressions, as well as non-verbal communication, is essential both to enhance the amount of information gained and to give the individual confidence that the health professional is interested in what is being said. Above all, it encourages the individual to believe that he or she has been heard and is perceived as a reliable witness. When the individual is providing a long, unbroken account, the health professional should pause the interview regularly to note the information. This helps the interpreter not to forget key points and allows the health professional to clarify points when they are still fresh in the individual's mind.

5.5 (e) Family members

As a rule, family members and friends must not be used for interpretation for two reasons. First, the quality of interpreting is generally inadequate, and second, there may be topics that the individual will not discuss in front of a family member, and therefore the risk of a failure to disclose torture is greatly increased. Many parents, for example, will not reveal details of their torture in front of their child. Furthermore, revealing such details in their presence may even lead to psychological harm for the child.

5.6 After the interview

5.6 (a) Team debriefing

After the interview(s), if a team is working together it must meet to debrief, ideally on every day that members are working. This is necessary both for the mental health of team members and to maximize the use of information (see sections 4.4 and 4.5).

First, those working with survivors of torture need to discuss how they feel about their work. When some team members admit to being distressed, it helps others who are feeling the same but are unwilling to disclose the fact. It also allows team members to identify colleagues who are in danger of burnout and who might need to take a break from the situation.

Those working with survivors of torture and other ill-treatment need to be aware of several psychological pitfalls. They may idealize patients, seeing them only as vulnerable individuals rather than as complex personalities with good and bad aspects. Thus they may become more deeply involved than might be appropriate and may become disillusioned if the client is later revealed not to have been completely honest. Had the professional taken a more balanced approach to the patient, this might not have happened. A team approach with regular peer review of cases, helps to identify this problem.

Second, the interviewer may generalize in the opposite direction, seeing all those alleging torture as liars or cheats. Some of those alleging torture might be fabricating stories for whatever reason. Others

may exaggerate their account but this does not necessarily indicate that the person is not a survivor of torture. Again, a team approach with regular peer review of cases helps to identify this problem.

A third danger is that of becoming inured by either hearing similar accounts over time or hearing accounts of such varying gravity that one account is found wanting when compared to another. Often survivors of torture

from a particular country or context tell very similar accounts because torturers employ fairly consistent methods or approaches. Interviewers should be prepared for such eventualities, and approach each case on an objective individual basis rather than comparing it to other cases.

The fourth danger is that of burnout. Having started with high ideals, the process of helping survivors of torture turns out to be slow and frustrating. The professional becomes depressed and cynical about the process, and becomes incapable of action. He or she should be helped to understand that the process is slow and that in the early stages there are few successes. The importance is for team members to share their feelings and experiences, and to celebrate the successes when they come. Where team members seem to be in danger of burnout, they need to be moved away for a time and receive psychological or emotional support.

SOURCE: Michael Peel and Noam Lubell with Jonathan Beynon, **Medical Investigation and Documentation of Torture: A Handbook for Health Professionals**, Human Rights Centre, University of Essex, 2005, with modification.

Available at http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

VI. MEDICAL EXAMINATION AND DOCUMENTATION

Torture involves the deliberate infliction of severe physical or mental pain. Thus the examination of an individual alleging torture has two distinct but related parts; the physical and the psychological examination. Undue weight should not be given to the physical examination since this may reinforce the perception that in the absence of any marks or scars that torture has not occurred.

While physical pain is a widely understood concept, reflecting the health professional's understanding of the physiology of pain receptors, nerve pathways and brain function, psychological pain is perhaps more difficult to quantify. However, by assessing levels of psychological distress and the psychopathological effects of specific experiences, some level of objective measurement can be obtained. There are, of course, individual subjective influences on both physical and psychological pain, but the health professional should seek to provide the highest degree of objective evidence of the degree of suffering. Ultimately it is for a judge to consider this and other evidence, and decide whether or not the threshold of torture has been crossed, but health professionals can be helpful in informing the courts.

The impact of torture is always psychological, and it is usually physical as well. The concept of the severity of the pain must apply to the totality of the individual's experiences. Thus to look only at the physical pain is insufficient. A pinprick does not generally cause severe pain, but when repeated regularly over a long period, with threats to use it on the genitals, or when it is implied that the needle is infected with HIV, the stress of the experience becomes very much greater. Being detained arbitrarily, without understanding why or for how long, and without recourse to challenge the detention can itself produce psychological distress and psychopathological effects, even without any physical assault.

Medical documentation in cases where there have been allegations of torture can therefore have several uses. It may corroborate or refute allegations of torture. A health professional can conduct a physical and a mental state examination of someone who claims to have been tortured, and give an opinion as to whether the physical or psychological sequelae found are consistent with the allegations made. Also, for example, if a survivor of torture alleges that a lesion was caused by being beaten, but the defence lawyers suggest it was a sporting injury, an experienced health professional might be able to say which of the two attributions was more likely.

A medical examination cannot usually prove torture conclusively, though it may help identify injuries consistent with torture. It is one part of the picture put together by the investigating authority. It cannot identify the perpetrator, nor tell whether the perpetrator was on- or off-duty, acting under orders or not. It may not even be able to determine definitively the cause of a particular injury except in general terms. However, when a detainee is known to have been in a good state of health at the time of arrest, it is then for the detaining authorities to explain any deterioration in the mental or physical health during or just after the detention.

6.1 Background

A health professional may be asked to examine a person alleging torture in a range of different contexts (see section 2.8). In all these cases it is necessary to take a systematic approach to the documentation of the allegations and findings. Since any documentation may have medico-legal implications it should be considered as a forensic examination. This section is intended to help health professionals in this position, with little or no forensic experience. Generally, medical examiners experienced at working with survivors of torture or other ill-treatment are willing to help colleagues if they are presented with a detailed situation and given sufficient time to respond.

Where possible, a health professional examining a survivor of torture or other ill-treatment should have access to basic facilities to treat the immediate clinical problems identified, and be aware of other colleagues or health facilities where the person can be referred if necessary.

6.1 (a) Medical history taking

If possible, the individual should be asked to give a chronological account of the incident(s) in question (see section 5.4). Sometimes this will not be possible, for example if the individual has had minimal education, or a degree of learning disability. A survivor who has had many episodes of detention and ill-treatment over the years may find it difficult to remember which episodes occurred on which occasion. In such cases it may be better to create a generic account, and then elaborate on those incidents that stand out.

Other reasons why accounts might be incomplete or incoherent include:

(adapted from The Istanbul Protocol)

- Factors during torture itself, such as blindfolding, drugging, lapses of consciousness
- Fear of placing oneself or others at risk
- A lack of trust in the examining health professional or interpreter
- The psychological impact of torture and trauma, such as high emotional arousal and impaired memory
- secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder [see section 6.2 (b)]
- Memory impairment from beatings to the head, post-traumatic epilepsy [see section 6.2 (f)], suffocation, near-drowning or starvation N Protective coping mechanisms, such as denial and avoidance
- Cultural norms that permit certain traumatic experiences to be revealed only in specific settings, if at all
- Forgetfulness or confusion falling within the spectrum of normal human recall.

These possibilities should be explored in detail. For example, the questioning of an account of loss of consciousness should try to differentiate true loss of consciousness caused by, for example, a blow to the head, from the effects of pain and exhaustion.

The history should include for each relevant incident:

1. The circumstances of arrest
2. The conditions of detention
3. Specific details of any alleged ill-treatment during detention
4. A subjective description of the person's mental state, and any changes, during the period of detention
5. A description by the individual of the acute appearance of any injuries at the time and how they healed
6. (with or without treatment)
7. Means of release or escape.

There should be a description of the individual's past medical history, where relevant, including previous experiences of trauma and any previous psychiatric history. The social background can also be relevant.

If the individual has some educational achievements documented, these can be used as indicators of the premorbid intellectual state (the psychological condition the survivor was in prior to the trauma). They can then be compared with the evaluation of the individual's present level of functioning, and judgments can be made about changes, and any possible causation.

The occupation of the individual is sometimes relevant to the documentation of torture because it might affect the differential diagnosis of any lesions. For example, someone who has worked in a professional kitchen may have scars from burns and scalds sustained occupationally. In such a case, the distribution and shape of the lesions may help to differentiate those following accidental injuries from those caused deliberately (although often a health professional can only say that either cause is possible: see section 4.6).

Occupation can also be a marker of educational attainment, and so can be evidence of a change in cognitive and/or psychosocial functioning. Statements from former colleagues, or documentation of work appraisals, can act as corroboration of this point.

6.2 Common pathologies

6.2 (a) Introduction

The examination of the individual alleging torture must be thorough but sensitive and include both a physical and psychological assessment. It is necessary to explain everything that is going to happen. The present mental state should be assessed throughout the course of the interview, with a specific mental state assessment as part of the examination [see section 6.3(a)]. For the physical

examination, generally the entire body should be inspected, because the individual might have injuries of which he or she is not aware, for example on the upper back. There may be scars relating to an incident that the individual has forgotten, for example running into barbed wire when escaping.

The assessment begins as soon as the health professional meets the individual, starting with the general appearance. Is he or she tidily dressed and well groomed? If not, could this be depression or is there a more practical reason? Do his/her clothes look too big, has he/she lost some weight? How does he or she respond to the health professional's introduction? Is the demeanour appropriate given the circumstances? Does he or she appear agitated or withdrawn? How does he or she move? Is he or she able to get out of the chair? Is there a normal gait? [See section 5.3 (a)].

The health professional should have a system to examine the patient, and it is important to ensure that the whole body is examined thoroughly, even where the individual does not think there are any marks. A neurological examination might also be necessary to evaluate motor and sensorial damage to peripheral nerves (see section 6.2 (i)] If the health professional is not the same sex as the individual undergoing examination, a chaperone needs to be present unless the patient firmly objects. The presence of a chaperone is primarily to ensure the dignity of the patient and address the unease of the individual, but can also protect the health professional from any subsequent suggestion of misconduct. The chaperone should be a staff member of the same sex as the person being examined and this function could be fulfilled by the interpreter if the individual agrees. Also, as mentioned above in section 5.3 (b) the patient should be offered the possibility to have a friend or relative present for support during the examination. It should, however, be kept in mind that the presence of a friend or relative could inhibit the individual from revealing certain intimate details. The final decision, of course, rests with the patient. To preserve the person's modesty and to prevent intrusive memories of nakedness in detention, care should be taken not to ask the patient to undress completely, but to uncover only the part of the body being examined. It is helpful to observe the mobility of the joints when the person takes off his or her outer clothes.

6.2 (b) Psychological diagnoses

Anxiety and depression are common among survivors of torture and other ill-treatment. Drug and alcohol misuse are also seen more than in the general population, probably as a way of avoiding unpleasant feelings and memories. Questions must be asked about these symptoms.

Anxiety and depression are common in this population and generally recurrent. They have experienced events, particularly unexpected events, that have left them fearful. Anxiety presents with feelings of hopelessness and helplessness. Persons are constantly worrying that other unexpected events may happen again, may feel uneasy and nervous, and may be prone to panic attacks. Therefore they tend to avoid situations that might make them nervous.

Depression presents as sadness, difficulty concentrating, tiredness and lethargy, loss of libido, inability to enjoy things, insomnia and early wakening, changes in eating pattern, mainly loss of appetite but sometimes binge eating, apprehension and fear, feelings of hopelessness and guilt. When severe there may be a preoccupation with death, thoughts of suicide, and sometimes attempts

at self-harm.

Acute stress reactions and post-traumatic stress disorder (PTSD) are both seen in victims of torture. They arise as a consequence of an event that threatens death or serious injury of self or others, leading to a response of intense fear, helplessness, or horror. Both are characterized by a specific set of symptoms. While the acute stress reaction occurs immediately after a traumatic event, PTSD occurs after a few weeks. The criteria necessary to make either diagnosis are given in Box 2 below.

Survivors of torture often complain of pain in different parts of their body; sometimes the description of the pain changes. The pain can be described as more or less intense and its location can change over time. Often there is nothing to find on physical examination. These are somatic symptoms and can be direct physical consequences of being tortured, or may be purely psychological.

Hallucinations, especially auditory hallucinations, are not uncommon, and are not necessarily symptoms of psychosis. They cannot always be differentiated from the re-experiencing phenomena of PTSD.

Dissociation, the feeling of being detached from one's self, is seen in victims of torture. It happens when a person lives through experiences that cannot become part of his/her memory (autobiographical memory) because of their intense character, as can happen during torture. There is a breakdown in the integration of consciousness, perception and behaviour. The person may feel as though he or she is observing him-or herself from outside. [See also section 6.2 (c)]

True psychosis may be identified, but before making the diagnosis, the symptoms must be evaluated in the individual's cultural context. For example, the person may hold ideas of being possessed or other forms of magical thinking, which may be culturally appropriate. A further complicating factor, regardless of culture, is that individuals may describe intrusive memories in a way that might appear to be hallucinations.

WHO International Classification of Diseases, 10th Edition (ICD10)

Reaction to severe stress, and adjustment disorders

This category differs from others in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ('life events') may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events or the continuing unpleasant circumstances are the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problems of social functioning.

F43.0 Acute stress reaction

A transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture and include an initial state of 'daze' with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor - F44.2), or by agitation and over-activity (flight reaction or fugue). Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within two to three days (often within hours). Partial or complete amnesia (F44.0) for the episode may be present. If the symptoms persist, a change in diagnosis should be considered.

Acute:
- crisis reaction
- reaction to stress

Combat fatigue
Crisis state
Psychic shock

F43.1 Post-traumatic stress disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, aesthetic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ('flashbacks'), dreams or nightmares, occurring against the persisting background of a sense of 'numbness' and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

BOX 2

6.2 (c) Memory

Self-reports of trauma and torture are often not believed or are felt to be distortions or exaggerations for secondary gain. Self-reported physical and psychological symptoms can also be construed as fabrications or exaggerations.

However, there is evidence that cognitive disturbances can follow a range of types of trauma. Many torture survivors have been subjected to physical injury to the brain from blows to the head, suffocation (including near-drowning), and starvation and other forms of prolonged nutritional deficiencies. These may lead to persistent cognitive impairment. Additionally, depression and PTSD affect cognition.

Memory impairment as a result of these factors may affect the accuracy of the details an individual is asked to provide about his/her torture. The inability consistently to reproduce detailed and precise recollections about times, places and incidents can reflect negatively on the individual's credibility. However, most of these factors are sufficiently well researched to allow the reasons for such discrepancies to be understood if they are explained properly to a court. It is the proper function of an expert witness to assist the court by reference to relevant research and other material within his or her field of expertise.

6.2 (c) (i) Normal inconsistencies in testimony

When a person gives several accounts of the same incident, there are inevitably variations in the description. There are several possible legitimate reasons for this. First, the individual might have misinterpreted what happened. For example, he or she might have been shot at while running away and felt a pain in the calf, which the person thinks is a bullet wound. If the lesion is too small to have been caused by a bullet, it might have been a piece of shrapnel. The individual could not have been aware of this at the time of the incident.

Secondly, memory wanes slowly over time, and people mis-remember events, although it is generally the more peripheral points that are forgotten while the core aspects are preserved. Thirdly, over time, some aspects take on more importance in a person's memory, while others appear less significant. Finally, people relate accounts according to their expectations of what their audience wants. Thus a doctor may be given an account with very different aspects focused on compared to the same incident being described to a lawyer.

6.2 (c) (ii) Pathological processes

Any head injury can lead to loss of episodic memory (memory of events or incidents from a person's past), even if there is no loss of consciousness [see section 6.2 (f)]. There will be a degree of retrograde amnesia (loss of memory for events immediately prior to the trauma) because the information stored in the short-term memory is not transferred into one of the permanent memory stores. There will then be some further prospective memory loss (loss of memory of the period immediately after the trauma) until the memory processes are functioning normally again. The period of memory loss is longer than the period of unconsciousness, and classically there are islands of

memory from periods when the individual is more alert.

Some survivors of torture experience episodes on which they appear withdrawn and unresponsive for a short time, and when they return to normal they have no memory of the episode. One possible diagnosis is complex partial seizures [see section 6.2 (f)], but there are several possible alternative psychological causes (although they could co-exist with epilepsy). One of these causes is panic attacks, although these generally last longer than a couple of minutes, and the sufferer is usually aware that he or she has not lost consciousness. Complex partial seizures (also known as temporal lobe epilepsy, TLE) have been misdiagnosed as panic attacks, and vice-versa. Brain tumours can mimic both syndromes. Also psychiatric problems such as depression and PTSD can interfere with normal memory processes.

Absences associated with memory loss are also seen in dissociation states [see section 6.2 (b)]. These are psychological states which usually start during severe stress (perhaps as a psychological protection mechanism), and recur with memories of the incident. Symptoms can be similar to those felt rarely in the aura of complex partial seizures, such as déjà-vu (the feeling of having experienced something before), mystical experiences, and awareness of the absence of thoughts. The main difference is that episodes of dissociation are much longer than those of complex partial seizures, lasting at least fifteen minutes, and normally for several hours.

6.2 (d) Early skin lesions

When the skin is injured it can respond in one or more of five ways:

- Contusions (commonly known as bruises)
- Abrasions (or grazes)
- Incisions (including stab wounds)
- Lacerations (also, commonly but confusingly, known as cuts)
- Burns and scalds.

6.2 (d) (i) Bruises

A bruise occurs following a blow that does not break the skin. Blood leaks from small blood vessels, making the area tender and sometimes boggy. If the skin and subcutaneous tissues are thin, the bruise becomes apparent relatively quickly and may take the shape of the weapon used, although this might not be obvious in darker skins. For example, a blow from a baton or heavy stick often leaves two parallel lines of bruising (tramline bruising) caused by the blood being pushed sideways by the contact. Ideally bruises should be photographed as soon as possible (see section 6.6), before they spread or fade.

When the bruise is deep the blood tracks slowly to the surface, and it may be several hours or even days before anything is visible. It is often helpful in such cases to re-examine the patient a day or two later. In such cases the extravasated blood (blood that has been lost from the vessels) follows tissue planes and may emerge some distance from the original injury, and is unlikely to be tender. For

example, bruising of any part of the face may appear below the eye. Thus the site of the bruise is not the site of the injury, but the size of the bruise could be evidence of the force of the blow. This should be made clear in any report.

In older people and those on certain types of medication, clotting is impaired and bruising is much larger than usual. This is particularly the case in those areas where the skin is loose. In these patients, for example, a minor injury on the neck can result in a large bruise. Dietary deficiencies of, for example, vitamin C (scurvy), can cause spontaneous and widespread bruising. This may be evidence of neglect of detainees. Extensive bruising not explained by the history should, if possible, be investigated in case it is the consequence of a disease. In writing such reports consideration should be taken about those possibilities.

Bruises change colour and fade over a period of hours and days as the blood pigments are metabolised and absorbed, but this takes a different amount of time in different parts of the body following a single incident. However, if there are bruises at different stages of resolution in the same place, this could support allegations of repeated assaults over several days.

6.2 (d) (ii) Abrasions

Abrasions are caused either by a blow with a blunt object or a fall onto a rough surface. Parts of the epidermis are rubbed away, sometimes in lines showing the direction of the impact. They are more likely to occur if the superficial tissues are thin, for example, over a bone.

During the two or three days following the injury, abrasions produce fluid that crusts over. This makes them very susceptible to infection, which delays and distorts the healing process. Unless the abrasions are full-thickness, they will heal with few remaining signs, although they can leave hyperpigmentation [see section 6.2 (e) (ii)] or hypopigmentation.

Abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. For example, ropes can cause abrasions wider than the rope itself. When the blunt force is directed perpendicularly to the skin over the bony prominences, it will generally crush the skin at that point. Sometimes, if there is anything between the object and the skin, its imprint may be observed on the skin. In hanging and other asphyxiation by ligature, patterned abrasions can sometimes be found on the neck.

Sometimes, survivors of torture may be thrown from moving vehicles so that they slide on the road, or they may be dragged along the ground during arrest or capture. In these cases extensive abrasions may be seen, and particles of dirt, sand, etc. will predispose the abrasion to infection. The same particles may become embedded in the skin and leave a sort of 'tattoo' effect that can persist for years.

Scratches are caused by sharp objects that produce superficial linear cuts. Identifiable patterns of scratches can be seen, for example, from fingernails.

6.2 (d) (iii) Incisions

Incisions are caused by sharp objects like broken bottles and blades that produce a more or less deep, sharp and well-demarcated skin wound. They must be differentiated from lacerations in which the skin is torn. The term 'cut' should never be used in a report, as colloquially the term usually means a laceration.

Incisional wounds have clearly defined edges and, on close inspection, it may be possible to see that hairs have been cut. There are no tissue bridges. Sometimes the wound can be jagged, suggesting that it was not caused by a single stroke. However, because the skin stretches as it is cut, the size of the wound is not necessarily related to the size of the implement used.

Small wounds and those that are supported by surrounding tissues heal at the surface, and they may be difficult to see after only a few days. If the wound is in a part of the skin that is not supported, it will gape. Unless it is sutured or otherwise closed, it will heal from inside.

Stab wounds are incisions that are deeper than they are wide. They should be examined carefully because of the risk of damage to deeper structures.

6.2 (d) (iv) Lacerations

Lacerations are caused by a tangential force such as a blow or a fall and produce tears of the skin. The wound edges tend to be irregular, and often any may be bruised or/and abraded. There might be tissue bridges (where the skin has not separated along the entire length of the wound).

6.2 (d) (v) Burns and scalds

Burns are usually caused by dry heat, but the skin can also be scalded with very hot liquids or burnt with chemicals. Burning is the form of torture that most frequently leaves permanent changes in the skin.

The shape of the lesion can sometimes, but not always, reveal the shape of the object that caused the burn. The damage caused by heat is proportional to the temperature and the duration of exposure. Burns are classified into three degrees, according to severity.

- In superficial (first degree) burns there is no permanent damage to the epidermis. They present as a reddening of the skin
- In partial thickness (second degree) burns some of the epidermis is destroyed and there may also be damage to deeper tissues. They present as moist, red, blistered lesions and are normally very painful
- In full thickness (third degree) burns there is complete destruction of the epidermis and significant damage to deeper tissues. They may not be as painful as partial thickness burns. If the burns are widespread, there is usually death from shock and fluid loss.

Cigarettes are commonly used by torturers to inflict pain. Most cigarette burns are superficial and fade over a few hours to a few days. They tend to be circular, have a diameter of up to 1 cm. They cause

an erythematous (reddening of the skin) and an oedematous circle that can blister. Deeper burns are caused when the lit cigarette is pressed against the skin for a long time. When this happens the lesion is deeper and there might be a full thickness burn in the centre surrounded by blisters. If the cigarette is rubbed in it leaves a larger and more irregular lesion.

Burns from hot objects tend to take the shape of the surface that caused the burn. The wound contracts as it heals, so the lesion may be smaller than the object. Liquids flow on contact with the skin, and this can leave a distinctive pattern reflecting the survivor's posture at the time of the incident. Scalds lose heat rapidly so the resulting lesion diminishes away from the point of first contact, whereas chemical burns are often more extensive. A number of lesions from scalding in different parts of the body are suggestive of torture. A single burn might be caused by torture but could also be due to an accident either at work or otherwise. A good occupational history is paramount.

6.2 (d) (vi) Complex lesions

Many lesions comprise areas of different types of wound. For example, as noted above, many lacerations are bruised and abraded at their edges. Wounds caused by broken glass may be a mixture of incision and laceration.

Bites tend to be a mixture of laceration and crush injury:

1. Human bites, especially those that are sexual in nature, can show petechiae from sucking. Petechiae are obvious in the twenty-four hours following the assault. The marks from human bites have a semicircular shape and appear blunt.

2. Animal bites cause deeper and sharper wounds. It is important to look for lacerations caused by the claws.

6.2 (d) (vii) Interpretation

Speculative judgements should be avoided in the evaluation of the nature and age of traumatic lesions since a lesion may vary according to the age, sex, condition, and health of the individual, the tissue characteristics, and the severity of the trauma. Fresh and old injuries can be seen together on people who have a long history of torture.

Infection, irradiation, corticosteroids, scurvy (vitamin C deficiency), diabetes, hepatic cirrhosis, uraemia, blood loss, cold, and shock all inhibit wound healing. Wounds heal faster in young people. Bruises resolve over a variable period, ranging from days to weeks. Estimating the age of bruises is one of the most contentious areas of forensic medicine.

6.2 (e) Scarring

It is often the case that a health professional will see a survivor of torture months or years after the incidents. In such cases the wounds are likely to have healed to a greater or lesser extent. Healing is influenced and often impaired by many factors that can be present in places of detention including

persistent, untreated infection; repeated trauma to the same area; and malnutrition. When faced with the examination of old injuries it is thus important to obtain a detailed history from the individual of the acute appearance of the injury, any treatment

received (such as sutures, antibiotics) and a description of how the wound healed and in what time frame. Such descriptions from a lay person may in themselves assist in corroborating allegations since they may indicate medical phenomena that a lay person would not usually be aware of. Such a description of wound healing may also reveal elements of the detention which are also deliberately neglected, such as:

- Inadequate healthcare provision
- Poor toilet and washing facilities
- Insufficient or nutritionally incomplete diet.

The commonest physical finding following the late examination of survivors of torture is scarring. Most is nonspecific, but some individual scars can be helpful in supporting a history of torture, as can the pattern of scarring. Occasionally the individual will have photographs of the acute lesions, and these can be very helpful in giving an opinion on the cause of the late signs. However, before citing such photographs in an expert report, it is essential to be certain of the date of the photographs, and that they really are of that individual (see section 6.6).

Full thickness wounds (those that go through the epidermis) heal in one of two ways. When the wound is small and the edges are opposed, it heals from the top down (by primary intention). This tends to leave a small, tidy scar. Pockets of infection inside can become abscesses.

If this process cannot occur, especially if the wound gapes, it heals from below (by secondary intention). This is a slow process and prone to infection, and will leave a wide scar. When the original wound was straight, and especially if it was an incision, the scar tends to be symmetrical, with curved edges, and is widest at the middle (a biconvex scar).

The number, position and size of lesions may indicate other aspects of the conditions in which the individual was detained. For example, if the floor of a cell is flooded for any reason, and there is no access to a toilet so that the person has to urinate and defecate in the cell, the detainees will have to sit or stand in dilute sewage. In these circumstances, minor wounds, whether caused by assault or accident, may well become infected and can leave many small scars around the lower legs or buttocks. These must be differentiated from lesions left by childhood skin infections. All scars should be documented, including those that the individual is clear were caused in incidents other than torture. If those detained in certain centres have far more such lesions than other individuals from the same social background, this should be documented.

If a scar has suture marks around it, this should be documented, as this demonstrates that medical care was given. Equally it should also be noted if there are scars from wounds that have clearly not

received medical attention, or have been seriously infected. Scars from surgery should also be noted, especially if it is alleged to be associated with torture, for example the removal of a ruptured spleen.

Sometimes scars are self-inflicted in order to support a weak medico-legal case, but these are often apparent. Generally they are superficial and within easy reach of the dominant hand.

Small regular patterns of scarring, particularly but not exclusively in Africans, could either be tribal marking or caused by traditional healers. The former are generally on the face. The latter tend to be multiple, symmetrical, and around painful parts of the body. However, some torturers may also produce small symmetrical patterns of scarring.

Bullet wounds are rarely caused during torture but may be caused prior to arrest or during escape. Generally, as a bullet enters the body it leaves a small, regular wound, but as it leaves the wound is much larger and more ragged. The appearance depends on the distance from the weapon and its type. If there is an entry wound but no exit wound, it may be appropriate to arrange an X-ray to find out if the bullet is still in the body. A photograph or, if a camera is not available, a drawing of the wounds might be helpful if an expert opinion needs to be sought.

6.2 (e) (i) Keloid scarring

Keloids are scars that exceed the boundaries of the original wound. They are much more common in some skin types than others. The exact pathogenesis is unclear, but the tendency to them is probably inherited. Those who have a tendency to keloid will probably have several thickened scars on their bodies. Thus such scars are more difficult to attribute to specific allegations of torture.

6.2 (e) (ii) Post-inflammatory hyperpigmentation

Hyperpigmentation can follow inflammation in darker skins, irrespective of the cause. It is not seen in pale skins, nor in very dark skins. The hyperpigmentation retains the shape of the original inflammation, which can be important forensically. For example, classic tramline bruising [e.g. parallel lines of bruising following a blow from a baton or similar object – see section 6.2(d)] or inflammation from burns can leave distinctive patterns of hyperpigmentation. The increased pigmentation can last for between five and ten years.

Whipping can sometimes leave lines of hyperpigmentation, especially in darker skin. These lesions are rarely confused with ***striae*** [see section 6.3 (d)] ***Striae*** are caused by sudden gain or loss of weight, so are also seen in some former detainees. They tend to be irregular rather than linear, and have a well-recognised distribution.

Less regular patterns of hyperpigmentation are seen following abrasions, again particularly in darker skins. Tight ropes or handcuffs may leave marks around the wrists, and marks following rope burns can be seen elsewhere on the body where the individual has been tied up or suspended. These are rarely pathognomonic individually, but the locations and distribution of the marks can support the history of torture.

As hyperpigmentation can follow any inflammation, any other cause of inflammation can cause a

similar pattern. For example, lines of increased pigmentation that follow an irritant dermatitis from contact with plant stems can be mistaken for similar lines following whipping (although it is not unknown for victims to be whipped with irritant plant stems as a form of ill-treatment).

6.2 (f) Head injuries and post-traumatic epilepsy

Head trauma is among the most common forms of torture. Even repeated minor head trauma can cause permanent damage to brain tissues. This can in turn cause permanent physical handicap. Lacerations and abrasions of the head and their late consequences should be documented as above.

Survivors of torture often report that they were unconscious at times, but it is impossible for them to know what happened unless they were with a reliable witness. It is necessary to try to differentiate between loss of consciousness following blows to the head, post-traumatic epilepsy (see below), asphyxiation [see section 6.3 (d)], pain and exhaustion, or any combination of these.

Many victims of torture have suffered blows to the head, and many complain of persistent or recurrent headaches, whether or not they have sustained any head injury. Generally the headaches are psychosomatic or due to tension headache [see section 6.2 (b)]. In some cases with a history of repeated blows to the head it is possible to feel areas of hyperaesthesia (extreme sensitivity of neurological sensation) and some thickening of the scalp from scar tissue.

Violent shaking of the upper body has been reported as a form of torture (as it has as a form of child abuse). Survivors complain of severe headaches and persistent changes in cognitive function. In these cases no injuries are visible. Shaking can lead to death due to cerebral oedema and subdural bleeding. Retinal haemorrhages have been noted on post-mortem examination and when seen in children are very suggestive of shaking injuries.

Immediately after severe head injury there may be concussive convulsions, but these do not necessarily lead to epilepsy. Convulsions in the first week or so after a severe head injury tend to be tonic-clonic. They may recur for a year or more, but are not generally lifelong. Severe head injuries leading to brain lesions, specifically in the temporal lobe, can cause convulsions that start months or years after the incident. These latter are complex partial seizures.

Typically (>90% of cases), complex partial seizures start with an aura (a strange feeling that precedes the convulsion). This is followed by an absence that can last up to two minutes. Concurrent automatic movements, particularly lip smacking have been reported. After these episodes there is usually a period of a few minutes of disorientation. Often the aura is described as a strange feeling in the stomach, but it could be bizarre smells or tastes. These must be differentiated from the re-experiencing phenomena of PTSD [see section 6.2 (b)] where the person is always capable of being roused and never completely loses consciousness.

In most countries the prevalence of epilepsy in the population is 2%. About 65% of epilepsy is due to complex partial seizures. The cause of complex partial seizures is unknown in 45% of cases. Traumatic events including birth events account for 3% of it. The likelihood of acquiring epilepsy after a head injury depends on the severity of the injury (see table).

Degree of head injury	Loss of consciousness	Relative risk of epilepsy	Duration of increased risk
Minor	< 30 minutes	1.5 (50% increase)	5 years
Moderate	< 24 hours	2.9 (three times)	
Severe	> 24 hours	17.2 (17 times)	20 years

Survivors of torture rarely have an accurate account of their head injuries, and unless they have an external reference, they cannot know for how long they were unconscious. One problem with attributing epilepsy to head trauma is that there is rarely any information about the individual's neurological state prior to the incident.

6.2 (g) Fractures

Beatings and falls can lead to fractures of bones. In the acute setting it is generally possible to diagnose a fracture clinically if no X-ray facilities are available.

Fractures can be caused by a direct blow, in which case the fracture is at the site of the impact, or by twisting or crushing, in which case the fracture tends to be at the weakest part of the bone. The commonest fractures in survivors of torture are of the nasal bones; the radius and ulna (bones of the forearm); the carpal, metacarpal and the phalangeal bones of the hand; the ribs; the transverse processes of the vertebrae, and the coccyx (the bone at the end of the spine, below the pelvis). (For further information see The Istanbul Protocol)

If fractures heal well, there will be no way of knowing whether the injury was caused by torture or by accidental causes. However, the fact that an injury can be demonstrated may be corroboration of the individual's account. It can also be significant if there are multiple fractures at different stages of healing. If the fracture has healed at an angle, or has become chronically infected, this may support an allegation of inadequate treatment at the time of the original injury. If old X-rays are available, new X-rays (if the equipment is available) can help to determine how long ago the injury occurred.

If a person alleges that a bone was fractured during torture and a callus is palpable, that should normally be sufficient to document. X-rays are unlikely to add anything. Generally, even with an X-ray, it is only possible to say that a bone was fractured within a wide time-frame, but very rarely that the fracture was caused by torture. Mal-united fractures are highly supportive of a history of torture with no immediate medical treatment.

6.2 (h) Joint damage

Many forms of torture involve damaging joints. Indeed the word 'torture' comes from the Latin ***torquere*** (to twist) because many tortures involved distending and twisting joints.

Suspension is a common form of torture, in which the individual is suspended by the arms or wrists. The body weight distends the shoulder joints, causing pain. In one variant, 'Palestinian suspension'

(also referred to as 'Palestinian hanging'), the arms are behind the back, increasing the strain on the shoulder joints and often stretching the nerves running into the arms.

Other forms of joint damage are specific to particular parts of the world. For example, the knees may be forcibly bent backwards around a heavy pestle, causing permanent damage to ligaments; or the thighs may be forced apart, damaging the adductor tendons (tendons running from the muscles that separate the thighs) which may remain tender for a long time afterwards.

6.2 (i) Nerve damage

Many forms of torture can cause nerve damage, including stretching injuries associated with joint damage and physical damage from fractures and incisions. The speed of resolution of nerve damage is relatively predictable, so it may be possible for an expert to determine the approximate time of the original injury from a series of examinations over several months.

'Palestinian suspension' can lead to neuropathy of the brachial plexus, especially if it has been prolonged. Sometimes there will be residual signs of this, and if they are still present after two years, they will probably be permanent. 'Winging' of the scapula must be looked for (by asking the person to push against a wall and observing the shoulders from behind). Survivors will sometimes describe having suffered weakness of the muscles around the shoulder associated with the loss of certain movements which have recovered progressively over a period of months. If he or she did not have access to information about the clinical processes involved, this description can be very supportive of allegations of torture. Often there is residual pain around the chest and shoulder joint which may be partially or completely physical or may be psychosomatic.

Peripheral nerve lesions of the hands and feet may also be detected following the prolonged application of restraints (wires, ropes, handcuffs, etc.) to the wrists or ankles. Motor and sensory changes may be transient or, in cases of excessive and prolonged tightening, may be permanent. These lesions are sometimes known as handcuff 'neuropathies'.

6.2 (j) Electrical injuries

Electric shocks have been used commonly by torturers for many years because they cause exquisite pain but rarely leave identifiable physical signs. The equipment can be as basic as the magneto of an old military field telephone or a couple of bare wires in an electrical socket to complex stun guns.

Magnetos are generally hand-cranked devices that provide a direct current (DC) related to the speed at which a rotor is turned – giving an opportunity to threaten the victim further. Mains electrical current can be delivered through bare wires touched against the skin, which might have been previously covered in water. Clips are sometimes used, and these can cause small lacerations when they pull off as the victim jolts with the force of the current. Some torturers have used fixed systems using switches or levers which again can be used to increase the threat of the torture.

Battery operated devices are portable but can still deliver a high voltage which may be alternating current (AC) or DC. Electric shock batons are being superseded by a range of devices including stun shields, remote control stun belts, and tasers, many of which were originally designed for law-

enforcement purposes.

Electrical torture uses the property of the electrical current to cause pain: in the body the current travels along nerves and blood vessels as they are the paths of lower resistance. As the current travels it causes contractions to the muscles involved and severe pain. These contractions can cause dislocation of joints and, if the chest muscles are involved, difficulties in breathing. If the current passes through the heart, arrhythmias (irregular heartbeat) can develop, leading to sudden death. Torturers apply electricity to the most vulnerable and intimate parts of the body. Genitals and breasts are often targeted and the victim is threatened on his or her reproductive capacity. When the current involves the muscles controlling urination and defecation those can occur without the victim being able to exercise control. The mouth also is very sensitive and often targeted.

Areas of reddening may persist for weeks. Occasionally the electrodes can leave small burns, probably from sparking. Both tend to be circular and less than 0.5 cm in diameter. These lesions may create hyperpigmentation [see section 6.2 (e) (ii)]. However, as these lesions are small they may be difficult to find. Although non-specific, they can corroborate allegations of electric shock torture, especially if they are in certain parts of the body. Studies have shown distinctive changes to cells beneath the site of the shock on microscopy, but such investigations should only be performed if they are essential to the legal case.

6.3 Order of examination

Where circumstances make it possible, it is advisable to conduct a full medical examination of the patient, including vital signs and anthropometry and physical examination, documenting the lesions caused by ill-treatment as part of the procedure.

6.3 (a) Psychological assessment

Torture always has a psychological component, as well as usually being physical, and in many cases the psychological state will be the most significant part of the examination. Although many perpetrators deliberately set out to destroy the mental stability of the survivor, sometimes the psychological damage is an unintended consequence of creating fear through physical abuse. Some of the psychological distress is caused by such issues as loss of control, losing the ability to trust, and a belief in the world as a just place, as well as feelings of guilt when others have been tortured as well.

During the history taking, the individual's past and present mental state should be evaluated. Ask, for example, about a typical day, visits to doctors, going to classes or work, and socialising. Distress may be visible, some individuals displaying it openly, while others attempt to keep it in check, often to the point of presenting in a rather detached manner.

Torture has variable effects on people because the social, cultural and political contexts vary widely (see above). Outcomes can be influenced by many interrelated factors that include but are not limited to the following:

- Circumstances, severity and duration of the torture
- Cultural meaning of torture/trauma and cultural meaning of symptoms

- Age and developmental phase of the individual
- Genetic and biological vulnerabilities of the individual
- Perception and interpretation of torture by the individual
- The social context before, during and after the torture
- Community values and attitudes
- Political factors
- Prior history of trauma
- Pre-existing personality
- Alcohol and/or drug misuse.

The psychological assessment of a survivor of torture, like all clinical assessments, is of two parts. Firstly, there needs to be a systematic discussion of symptoms, including sleep disturbances, behaviour changes, and mood. Some of these elements may be corroborated by family members or those sharing accommodation. Secondly, the health professional must be aware continually of the individual's demeanour, and how it changes when particular topics are discussed. Thus it is possible to get a degree of objectivity in the psychological assessment.

Most survivors of torture describe a range of psychological symptoms, although they may not perceive them as medical problems. Psychosomatic symptoms are particularly common, but many survivors come from cultures where the Western concept of the mind/body split does not exist. The symptoms include sleep disturbances, particularly lying awake worrying, then waking with nightmares when they do get to sleep. Sometimes it is difficult to differentiate between nightmares and intrusive memories. Feelings of depression and anxiety are common, although they can be a consequence of post-torture or non-torture experiences such as becoming a refugee. There may be changes in behaviour to avoid stimuli that remind them of the trauma. It is rarely possible from the symptoms described by the individual to establish the original trigger.

Torture does not always produce persistent psychological problems. Thus, in the same way that survivors of torture can have no identifiable physical problems, if an individual does not have mental problems, it does not mean that torture has not occurred. When there are no physical or psychological findings, this can neither support nor disprove someone's allegations of torture.

The psychological impact of ill-treatment depends very much on the prior awareness of the individual. Someone who is politically active might be able to undergo substantial torture without necessarily developing persistent psychological symptoms because he or she could have anticipated the experience, and put the episode into a personal and political context. However, someone who was arrested simply as a result of being in the wrong place at the wrong time might not suffer much ill-treatment, but could still be devastated by the experience, because the incident was not anticipated and the person was not sustained by a political ideology or religious faith.

One aspect of torture that makes it harder to cope with is the complete unpredictability of events. Some perpetrators deliberately change routines so that survivors never know what to expect. The opposite approach is also used, of torturers assaulting the victims at exactly the same times each day.

The same symptoms probably occur in survivors of torture from every socio-cultural background, but torture has unique social and political meanings for each individual. This will affect both the

individual's ability to describe the experiences, and the impact that the torture has inflicted on them psychologically. Thus the symptoms that the health professional is seeking might not be the symptoms that concern the individual the most, and he or she might not interpret them in a biomedical manner. For example, intrusive memories may be interpreted as a supernatural experience. Therefore the health professional's inquiry has to include the individual's beliefs about their experiences and meanings of their symptoms.

The mental state exam begins the moment the health professional meets the subject. The interviewer should make note of the person's appearance (such as signs of malnutrition, lack of cleanliness), changes in motor activity during the interview, use of language, presence of eye contact, and the ability to relate to the interviewer (see Box 3 below).

Brief mental state exam

- Appearance - self, clothing, marks
- Behaviour on observation (e.g. does s/he look perplexed)
- Look and smell for signs of alcohol, drugs, disease
- Assess speech - form, content, flow
- Mood, subjective as the patient defines, objective (affect) as the clinician observes
- Thought processes (delusions, obsessions, ideas of helplessness, morbid ruminations, etc)
- Perception, illusions and hallucinations (auditory, visual, olfactory and somatic)
- Cognitive function (i.e., orientation, time, place, person, short-term and long-term memory)
- Insight (how aware the patient is of his or her psychological problems)

BOX 3

Interpretation of the clinical findings is a complex task. The following questions will help reach conclusions (adapted from: The Istanbul Protocol):

1. Are the psychological findings consistent with the alleged report of torture?
2. Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
3. Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where in the course of recovery is the individual?
4. What are the co-existing stresses impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?

5. What physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture and/or detention.

6. Does the clinical picture suggest a false allegation of torture?

6.3 (b) Upper limbs

Small wounds to the backs of the hands can be caused by punching or being hit. Wounds on the backs of the forearm could be defence injuries. The inside of the non-dominant forearm is the usual location of self-inflicted wounds. [See also section 4.6(a)]. Superficial abrasions or reddening around the wrists could have been caused by tight handcuffs or cords. At a later stage there is often hair loss and there may be hyperpigmentation [see section 6.2 (e) (ii)]

Finger and toe nails can be extracted or crushed during torture, but the late appearance is normally indistinguishable from infection or innocent trauma. Vaccination scars should be noted to ensure they are not attributed to ill-treatment.

6.3 (c) Head and neck

Lesions on the face are particularly distressing for survivors of torture because they are a frequent reminder of the episode. Most traumatic scars on the face tend to be relatively small, and scars from acne and chickenpox, and tribal markings, must not be mistaken for them.

Lesions are common over bony points, especially the eyebrows and the cheekbones. These may be associated with a fracture of the malar bone (cheekbone). Subconjunctival haemorrhages (bleeding seen in the white of the eye) should be noted. Sometimes victims of torture complain of soreness in the eyes after a history of long detention in dark cells; on examination mostly only redness of the eye is apparent.

Bruises and scars in the scalp can be difficult to find, especially if the hair is thick. Bruises will normally be tender to touch. Broken or missing teeth are often shown by individuals as evidence of assault, but where the general oral hygiene is poor this usually makes this sign unhelpful. Petechiae of the palate may be evidence of forced oral intercourse (see section 6.4). Slaps to the ear can sometimes damage the eardrum. However, the finding of scars of the tympanic membrane (eardrum) does not exclude childhood infections.

6.3 (d) Chest, back and abdomen

Lesions on the trunk, as in all parts of the body, can be accidental or self-inflicted, or a consequence of torture. The late effects of whipping and beating with sticks can include lines of hyperpigmentation as well as scarring. Sometimes torturers embed small pieces of metal in whips, or hammer nails through sticks, and these can leave a distinctive appearance.

Striae distensae (stretch marks) are most common on the abdomen (especially after pregnancy), the lower back, the upper thighs, and around the axillae. They are hypopigmented lines in which the skin might be folded. They must not be confused with scars from whipping. In *striae*, the skin is intact. They can be evidence of significant weight loss, for example in detention. [See also section 6.2 (e) (ii)]

Survivors of torture frequently complain of non-specific pains, and the chest is a regular site for them. On examination there is rarely anything significant to find, except perhaps some tenderness of the chosto-chondral joints (joint between the rib and the sternum (breastbone)). The pain is often helped by sympathetic physiotherapy. Patients with acute rib fractures should be examined thoroughly to ensure that there is no damage to underlying tissues.

Back pain is also common in survivors of torture, and there may be some local tenderness in the lumbar spine. However, these findings are non-specific and common in the general population. Fractures of the vertebral pedicles (the parts of the vertebra going away from the main body) may result from direct blunt force and in some instances radiography of the vertebrae may indicate recent or healed fractures.

Partial asphyxiation is very frightening for the victim and torturers have used many methods of causing it. These include putting plastic bags or other sealed objects over the head, holding the head under water, and forcing objects into the mouth, such as a wet cloth. Sometimes chilli pepper, petrol or sewage are added. Victims can be exposed in a confined space to smoke or tear gas. Many survivors will give an account of a persistent dry cough for a few days or weeks afterwards, probably as a result of inhalation pneumonitis (inflammation of the lungs). Some survivors say that they have been asthmatic since such an incident, but it would be very difficult to demonstrate causation. Examination of the lungs, and respiratory function tests are usually normal.

Incision wounds to the abdomen can be mistaken for surgical wounds, including those from surgical drains, and vice versa. If the wound was not sutured properly, this increases the likelihood of it not having been made surgically. The location of the wound is always helpful. Renal failure due to crush syndrome may be seen acutely following severe beatings, severe burns and electrical torture.

6.3 (e) Lower limbs

Scars on the knees and shins are common in many people, especially those who have played contact sports. Thus lesions in this part of the body can rarely be significant, though they might be consistent with allegations of torture (see section 4.6). Additionally, tropical ulcers in childhood can leave large, irregular scars primarily around the lower legs. Lesions on the upper thighs and particularly those inside the thighs are much more important, as they are less likely to be the result of disease or accidental causes.

Falaka (beating of the feet) is a common method of torture, particularly around the Mediterranean and in the Middle East. Survivors will usually describe painful, swollen feet for days or weeks after the torture. Some will describe pain on walking several years later, or burning pain in the foot radiating up to the calf or even the thigh in bed at night. There may be some tenderness of the sole of the foot on palpation. However, the recognized syndromes of permanent damage to the foot probably only occur in those whose feet were beaten most severely.

6.4 Sexual assault

Sexual assault is probably common worldwide as a form of torture, but less widely discussed.

Perpetrators generally claim that torture is necessary to gain information, but sexual abuse suggests a motivation more to debase, humiliate and intimidate, not only the victim, but often the family and even the wider community. Survivors of sexual assault are often unwilling to disclose the abuse openly. In many cultures victims are blamed, even though they were powerless at the time of the incident. This makes it even less likely that they will testify against their torturers.

All forms of torture include an element of humiliation. Although far fewer women than men are detained, those women who have been tortured in detention are disproportionately likely to have been sexually abused and raped. If there has been no other torture, this can be very difficult to document, as the opinion may have to be based on the demeanour of the woman and her description of what happened to her and of her psychological symptoms. As many as 25% of all male survivors of torture have been sexually assaulted. If there are conclusive physical signs from other forms of torture, a survivor may not disclose sexual abuse. It is necessary to be sensitive to this during the history taking, as it is important for a health professional treating the individual to be aware of it.

Children may also be victims of rape and sexual assault. Even older children may be unaware of what happened to them, and may not be able to give a coherent account of their experience. Using drawings and, if available, dolls may help them explain where they do not have the necessary language or understanding. It is even more important that the examination is by someone who is experienced in this field.

Sexual abuse often occurs in the context of detention and ill-treatment. Several patterns can be identified. In one, the genitals are treated like any other parts of the body and they are assaulted with the rest of it with the aim of hurting. Giving an electric shock to the genitals is just another way of causing severe pain.

In another pattern, particularly in societies where extramarital sexual activity is taboo, the victim will be criticised for the sexual act, even if it was perpetrated when he or she was unconscious. This in itself is an obstruction to disclosure, and a threat by the perpetrator to publicise the rape can itself be very harmful. Sexual assault and rape are intended to add to this by maximising the humiliation as well as the pain of the torture.

A third pattern is where detainees are treated like prizes. The guards, often drunk, abuse and rape the detainees. Although such activity is said to be the guards acting for their own gratification, it is often systematic and widespread and part of the humiliation of the detainees.

The sexual assault is clearly not simply a physical assault on the individual, but in many instances it is the psychological insult that is most injurious. Often, sexual assaults will be accompanied by direct or implied threats. In the case of women, the threat may be one of becoming pregnant. For men, those inflicting the torture may also threaten (incorrectly but usually deliberately) that the victim will become impotent or sterile. For men or women there may be the threat of contracting HIV or other sexually transmitted infections (STIs) and often the threat or fear that sexual humiliation, assault or rape will lead to ostracism from the community and being prevented from ever marrying or starting a family. Sexual assaults can be categorised as:

- Assaults to the genitals
- Electric shocks to the genitals and anus
- Forced sexual acts on themselves or on/with others
- Object inserted into the vagina (in women)
- Object inserted in the urethral meatus (in men)
- Object inserted through the anus
- Penis forced into the mouth
- Penis forced through the anus
- Penis forced into the vagina (in women)

The term 'rape' always means the last of these, but in many jurisdictions it can mean one or more of the others. Thus if the term is used, the act should also be specified.

Following the above, when examining an individual who may have been sexually assaulted, the health professional should be aware of and sensitive to the particular unease that the individual is likely to be experiencing, and should take note of gender and culture considerations and the use of chaperones [see sections 5.2 (b), 5.3 (b), 5.3 (c), 5.5 (b), 6.2 (a)]

6.4 (a) Examination of women

Lesions on the breasts, particularly from bites, should be enquired about in women who have been sexually assaulted. When the legs are examined, the inner thighs should be inspected thoroughly. Where women have had their legs forced apart, there may be finger bruising, scratches, cigarette burns, incisions and other wounds, or their late consequences.

The vaginal examination is generally the last part of the physical examination. The doctor must seek specific consent prior to a genital examination, even if consent for the physical examination has already been given. Prior

notice of an intention to conduct a detailed physical examination that may include a genital examination could be reassuring to the person and help her to give informed consent. A clear, unambiguous explanation of the reason for the genital examination should be given while the victim is fully clothed. Rape victims in particular may feel disempowered, and may feel that they cannot refuse a request from the doctor, who should make every effort to ensure that any consent given is real and informed.

If the victim refuses consent, the doctor should record any relevant observations on the victim's demeanour, such as embarrassment or fear. It is unwise to draw conclusions about a refusal to consent to genital examination. Lying prone on an examination table, exposed and with legs apart in front of a relative stranger, can trigger powerful recall of the rape. The victim may be anxious, and shame can be profound, making genital examination unacceptable to her.

If informed consent is obtained, the woman should be made at ease, reassured and explained the procedures that are going to be performed. The genitals should be inspected for the presence of a hymen, the likelihood of having been pregnant, and evidence of genital mutilation. Is there vaginal discharge or tenderness, or spasm of the vaginal muscles?

If the woman is being examined shortly after the rape, it is important to discuss issues of pregnancy and emergency contraception, and however long has passed since the assault, sexually transmitted diseases (especially gonorrhoea, chlamydia, syphilis and trichomoniasis) and other infectious diseases such as Hepatitis B (HBV) and HIV must be considered (see below), and treated where present if the necessary facilities are available. If rape occurred within the previous seventy-two hours, consideration must be given to the administration of post-exposure prophylaxis (PEP) of anti-retrovirals (ARVs) for preventing infection by HIV and this depends on a detailed assessment of the nature of the sexual assault. The risk of infection with HBV should be assessed and the need for immunization determined.

Some women are raped persistently over a long period which increases the likelihood that they will become pregnant; in some cases they are then detained until it is too late to consider termination of pregnancy (if that would otherwise be an option). In such cases routine ante-natal examinations should be performed including, if possible, ultrasounds. This will enable the time of conception to be estimated.

6.4 (b) Examination of men

As for women, the men's genitals are best examined last. The skin of the male genitals is tough and wounds are an indication that considerable force has been used. Wounds then heal with relatively small scars. It is therefore necessary to examine the area thoroughly if there is a history of injury, or if electricity has been applied through clips. As for women, the insides of the thighs may also have been injured.

Men who are sexually assaulted in detention may develop an erection and sometimes ejaculate. This is often quite distressing. It can be a physiological response to stimulation of the prostate following anal penetration, and/or a consequence of emotional arousal from anger, fear and pain. Survivors should be reassured that this can happen to any man irrespective of his sexual orientation.

As with sexual assault of women described above, male victims of sexual violence also need to be assessed for prophylaxis of sexually transmitted diseases, Hepatitis B and HIV.

6.4 (c) Perianal examination

The examination of the patient alleging sexual torture is not technically different from a general anogenital examination. The essential aspect, even more than for other medical purposes, is to gain the confidence of the individual. By this stage the health professional will have already completed an interview and general physical examination.

Following a more general history, questions should be asked about urinary function after the episode(s). Some survivors of torture described haematuria for a median of two days, mostly after beating or electric shocks to the genitals, although some could have had haemaglobinuria (haemoglobin in the urine) from beatings elsewhere in the body. Where an object has been inserted into the anus, including anal rape, there is normally bleeding and pain for a few days afterwards, but these symptoms do not normally last for more than about two weeks.

Generally, visual inspection of the anogenital region is sufficient to find scarring and other lesions of the skin. The focus of the examination will depend on the history.

Anal rape or objects pushed through the anus in either sex can sometimes lead to scarring. Scarring from haemorrhoids or anal fissures is seen in a proportion of the general population, but may also relate to constipation due to a poor prison diet. If a health professional sees scarring in an unusual part of the anus, or scarring that is bigger than commonly seen following anal fissures, this should be emphasized. .

It is best to examine the anus with the patient lying on her or his left side. The buttocks can be separated gently to see if there is any perianal scarring. It is only necessary to check the tone of the anal sphincter if the survivor has been anally raped repeatedly. If the survivor had persistent bleeding after an object was pushed through the anus, there may be scarring of the rectal mucosa and this can be looked for by proctoscopy.

Following rape, the possibility of sexually transmitted diseases should be considered and local protocols followed. If there is any possibility of the perpetrator being prosecuted, air dried internal and external anal swabs can be taken up to five days after the rape, even if the survivor has defecated, and stored for DNA testing.

6.5 Investigations

The use of clinical investigations of allegations of torture may take two forms. First, health professionals who examine a survivor of torture during their routine practice may need to conduct investigations as part of their therapeutic role. While these investigations are primarily part of the diagnostic and treatment process, they may

well serve as forms of documentation that can be referred to later. The second form of investigation may be that which is carried out during the course of an examination dedicated to the medical documentation of torture. The latter investigations aim specifically at the production of medical evidence that may corroborate or rebut allegations of torture.

The investigation of allegations of torture will depend on several factors. First, the resources available might be limited in some resource-poor countries, and it would be unethical to divert valuable clinical resources for medico-legal purposes. However, the results of investigations such as X-rays taken for clinical purposes can be important pieces of evidence.

Second, the nature of the investigations will depend on the level of proof necessary for the situation. Unnecessary X-rays, for example, increase the radiation exposure of the individual and of the community and should be avoided. Only if such investigations are likely to make a significant difference to the case can they be justified.

Additionally, some survivors will have been tortured using, for example, electric shock devices, and being examined using medical equipment might trigger intrusive memories.

Where investigations are indicated, and the individual consents, possible investigations include X-rays, ultrasound, CT scans, MRI, and scintigraphy. Studies have also shown pathognomonic changes in skin biopsy for several months following electric shocks [see section 6.2 (j)] In many of these cases, the findings wane after about a year, and it must always be emphasised that negative findings after an investigation cannot be construed as evidence that the alleged torture did not occur.

6.6 Medical photography

One helpful tool in the documentation of physical assault is photography. It may be possible to ask experts elsewhere to comment on photographs if there is no local expertise available to interpret them. Those interviewing in custodial settings may not be permitted to use such equipment, but it can sometimes be negotiated with the detaining authorities.

When working with a person who is alleging recent torture, it is very helpful to be able to document the injuries as quickly as possible, before any change occurs. Any photographic equipment can be used to capture a wound in the first instance and more photographs can be taken later, with a better camera if possible.

The subject of clinical photography must consent to having the pictures taken and agree about how the photographs will be stored and used.

The first photograph should show the individual clearly with, if possible, the lesions visible to allow identification in court if necessary. The front page of a recent newspaper (or other object of verifiable age) can demonstrate that the photograph was not taken prior to that date. If there are date and time settings on the camera, these should be used correctly. There should always be an indicator of scale for close-up images. A tape measure is best but, if necessary, any well-known object of standard size can be used, such as a 35mm film canister or a coin. In photographs taken using the camera's built-in flash, wounds tend to be obscured. It is better to work in daylight or to use background lighting.

Digital cameras allow many photographs to be taken using different angles and lighting conditions and the best produced as evidence, although every image taken should be stored securely (for example, on a secure computer, with password protection). Films can also be useful as courts have not generally agreed how digital images should be treated as evidence. Digital images and scanned prints can be useful as they can be e-mailed to experts for an opinion. If necessary they can be cropped and enlarged, but the original version must always be retained. Further interference must be avoided as allegations of manipulation are difficult to refute.

Once the photographs have been taken, the chain of custody of the images must be ensured. A 'chain of custody' is a detailed record showing the exact date, time and location in which a piece of evidence entered the possession of different individuals. A chain of custody aims to prevent outside interference with evidence. It may be valuable to add to a witness statement a phrase such as: 'I took photographs of [name] on [date] using my [type] digital camera. I kept it in my possession until I transferred the images to [X] directory on [X] computer. To the best of my knowledge it has not been tampered with, and the photographs in this report were made from that file.'

SOURCE: Michael Peel and Noam Lubell with Jonathan Beynon, **Medical Investigation and Documentation of Torture: A Handbook for Health Professionals**, Human Rights Centre, University of Essex, 2005, with modification.
Available at http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

VII. VISITING PLACES OF DETENTION

7.1 Why visit places of detention?

Visits to places of detention are seen as one of the cornerstones of the prevention of torture, firstly since they can have a direct deterrent effect, and secondly because the members of a visiting team can directly observe, document and report on the conditions of detention and treatment of detainees. Visits serve to break down the idea that prisons and other detention places are 'closed institutions', and thus to increase the transparency of their functioning.

A third but no less important role of visits is the psychological support that they may bring to the detainees. This support is not through therapeutic procedures, but often the mere presence of someone from outside who acknowledges the existence of the individual and thus provides a link with the outside world is of value. Visiting a place of detention may also facilitate the re-establishment of contact between the detainee and the family, or between the detainee and a legal advisor or other external source of support or assistance.

7.1 (a) Places and stages of detention prone to torture

As described in earlier sections, the most common period for torture to occur is during the phase after initial arrest. Thus torture more commonly occurs in the hands of security forces (police, gendarmerie, military etc.), in short-term places of detention, which may be official, recognized places, but which are sometimes also unofficial or secret places of detention. Visiting teams may have little or no access to these places, or if access is granted, detainees may be moved or hidden before the team arrives.

Access is often more likely to be granted to regular prisons, where detainees who are under-trial (on remand) and prisoners who have been convicted, are held. In these prisons, the visiting team and those detained may be more concerned with the conditions of detention and other issues such as fundamental judicial guarantees. However, it is important to keep in mind that especially in remand prisons, detainees who have undergone torture and other ill-treatment in a previous place of detention to which the visiting team may have no access, may well be present and the circumstances and events of the ill-treatment can still be obtained through detailed interviews with the individual. A picture of the layout of the place where torture took place, the general conditions, food, hygiene, medical care and specific methods of ill-treatment can be built up through cross-checking with as many individuals as possible who have passed through the same place

7.1 (b) Constraints on documentation during visits to places of detention

Visits to a place of detention do not usually provide the ideal conditions for documenting allegations of torture or other ill-treatment which have been described in the previous sections. This is most commonly related to constraints on time that can be spent inside a prison and the number of prisoners who are present. The fears and concerns of the prisoners (for example, of reprisals, of interviewers maintaining confidentiality etc.), the near-by presence of guards or indeed of other prisoners, may also inhibit them from talking. Although, at first glance, it would appear that conducting interviews under such controlled conditions as prisons would seriously impede the process, it is often the case that detailed and useful information can be obtained after carefully

identifying the team, their organization, the aims and purpose of the interviews, and how the information will be used

7.2 What to assess in a place of detention?

As described in Chapter II of this Handbook, in describing or determining what is torture and other ill-treatment it is important to stress that these terms apply not only to the treatment inflicted during an actual interrogation session, but may also cover the general conditions of detention in which people are held. If the conditions of detention are deliberately harsh with a view to causing more suffering to the individuals, or there is simply wanton neglect of the basic necessities for daily life, then this may in and of itself amount to cruel, inhuman, degrading treatment and/or even torture. Particular forms of detention, such as prolonged use of solitary confinement, may in themselves be a form of ill-treatment.

7.2 (a) General conditions of detention

Establishing an accurate picture of a place of detention is a question of compiling information from three main sources: the prisoners, the authorities and one's own observations. It is important to document not only specific physical and psychological methods of interrogation, but also the living conditions, including hygiene of the premises, access to and quality of food and water, access to personal hygiene, including toilets and the state of the facilities, and access to health care. It is clear that poor general conditions of detention, particularly poor nutrition, poor medical treatment, exposure to insects and other vectors of disease etc, may all lead to physical as well as psychological symptoms and signs. It is well documented that the prolonged use of isolation can lead to specific psychological as well as some physical sequelae

7.2 (b) How much time to allow for visits

The depth of the information that the visiting team is able to gather depends partly on the type of place being visited, the size and [illegible] of the visiting team, and the amount of available time. Commonly, police stations hold smaller numbers of detainees in small facilities, and thus a visit may be conducted in a day or less. On the other hand, prisons in different contexts may hold as few as fifty prisoners or up to several thousand and a visit may need several days.

For a large prison, careful planning of the objectives of the visit, division of the tasks and selection of individuals to talk to will have to be made. In visiting places of detention where individuals may actually be subjected to ill-treatment (interrogation centres, police stations, military and paramilitary camps), the visiting team should not press the detainees too much for information, since they will usually be extremely fearful of reprisals in the event that they are seen to have complained in any way about their treatment. More detailed information can be gathered from detainees at a later stage when they reach a mainstream prison or other more long-term place of detention.

7.2 (c) Documenting specific methods of torture or other ill-treatment

As well as documenting the conditions of detention it is crucial to document specific methods of interrogation that may variously be used on individuals. It is important to understand that the methods used may be physical or psychological or more usually a combination of both. In many cases, it is a combination of methods (whether physical, psychological or both) which are

collectively seen as torture or other ill-treatment. The length of time over which an individual is subjected to certain treatment may also affect the determination of whether this is torture. Again, for these reasons, it is important to document as accurately and completely as possible all the events to which an individual was exposed, and their consequences, and not be overly concerned at this stage about legal thresholds or definitions.

If the allegations of torture relate to a place of detention previous to the one where the interview is being conducted, the same detail of information on conditions and specific methods of interrogation should still be collected.

The same methodology as detailed in the previous sections of this Handbook should be applied, but the constraints of the location (within a prison or even a police station) and time will mean that the team will have to abbreviate much of the process. Nevertheless, the team should obtain a description of the conditions of detention, in particular the cell, block or barrack where the person was held, noting any degree of over-crowding present, and other elements such as the bathroom and toilet facilities, amount of time allowed outside of the cell; the frequency, quantity and quality of food and water; the level of health care available. When describing elements such as bathing facilities and health care, it is not enough simply to describe the structures, it must also be ascertained how the person accessed these facilities and what barriers there were to such access. For example, there might be discrimination of access to health care, food or even exercise for some minorities, foreigners or political groups.

Then, in relation to interrogation, there should be a description of the methods (physical or psychological), the immediate or acute effects on the person, any medical (including psychological) treatment received at the time and the immediate healing or recovery phase following the events. Then the health professional should ask about any lasting or chronic physical or psychological disturbances which may be related to the previous detention and any further medical, psychological or psychiatric care and how this has affected the evolution of any symptoms. This should be completed with a brief physical examination focusing not only on the systems that relate to the person's symptoms, but also those systems in which the health professional would expect to find signs that would relate to the detention or interrogation described. There should also be an abbreviated mental state examination, but many elements of this can be noted during the course of the interview itself.

7.3 Composition of the visiting team

The monitoring of places of detention can take place at both a national and an international level.

The composition of the visiting team may vary, and depends partly on the mandate of the team. From the above description of what to assess, it can be seen that 'health', in the broad sense of the term, is a crucial aspect for assessment. Thus a doctor should ideally form part of the team, but certainly where the documentation of individual survivors of torture is likely.

When the team is composed of international members it will usually be necessary to use interpreters. In order to ensure confidentiality, and to build trust with the prisoners it is preferable to use expatriate interpreters who may also be able to assist with providing background cultural and contextual information to the team (see also section 5.5 on working with interpreters). If, during a visit where no interpreter is present, it becomes apparent that a prisoner needs to be interviewed

via an interpreter, the prisoner him- or herself should be asked to choose a fellow prisoner to assist him. The team should always keep in mind that in using fellow prisoners as interpreters they may relay confidential information to third parties and so should always exercise caution when doing so.

National visiting bodies may include a system of 'lay visitors' (often only with access to prisons); the Office of the Ombudsmen or National Human Rights Commission; parliamentary commissions; independent NGOs etc.

International visiting bodies may cover specific geographical regions, or may be able to conduct visits around the world. The European Committee for the Prevention of Torture (CPT) has a mandate to visit places of detention (which include not only prisons and police stations, but also institutions such as psychiatric hospitals, homes for the elderly, orphanages etc.) throughout Europe, even in the absence of any complaints or allegations. The International Committee of the Red Cross (ICRC) has a mandate to work in areas of armed conflict across the globe and to visit places of detention (military camps, police stations, interrogation centres, prisons etc.) in these contexts. In the case of international armed conflict the ICRC has a right to visit both prisoners of war (POWs) and civilians who are interned; that is, states are obliged to allow access. In the case of non-international armed conflict or even situations of internal unrest in a country, the ICRC can offer its services to visit people deprived of freedom; that is they may only visit places of detention with the permission of the state authorities, which many states do indeed grant. The aim of visits in all these contexts is to prevent or end torture and ill-treatment, disappearances and extrajudicial killings, as well as to address the overall conditions of detention, including health care.

The Optional Protocol to the United Nations Convention Against Torture (OPCAT) incorporates a dual system for the prevention of torture through the establishment of both international and national bodies to visit places of detention. Both categories of monitoring mechanism should include a doctor as part of the team

7.4 Safeguards for visits

Effective visits to prisoners for the purpose of documenting torture depend upon certain conditions and guarantees, without which they should not be attempted. It is essential in any visit to prisoners to be able to interview all persons concerned, and who freely accept to be interviewed, in conditions of safety and privacy. Non-adherence to these conditions could further compromise the safety of those interviewed. Wherever feasible the visiting team should choose the location in which they wish to interview individuals, and choose for themselves which prisoners they wish to meet. Additionally, the team or others on their behalf, should be able to repeat the visit at a date in the future in order to check that no reprisals have taken place, and that all the prisoners are accounted for.

7.4 (a) Choosing which prisoners to talk to

It is clear that in most prisons it will be impossible to interview each and every prisoner, and thus the team should select a sample of prisoners. There is no single formula for sampling of prisoners, but during the tour of the prison the team should look out for certain individuals such as the obviously sick, the quiet withdrawn individuals, prisoners who appear particularly young or old. There may also be prisoners from particular sections of the prison that the team wishes to

interview, such as those in punishment cells/solitary confinement, the women's section, the juveniles' section, those in the prison hospital etc. If the team has a good knowledge of the patterns of torture in the country and knows that particular police stations or interrogation centres are responsible, the team might select those prisoners who have passed through these places, or who come from those particular regions or towns (although care must be exercised since this may clearly indicate to the authorities the purpose of the interviews). Equally the team may decide to interview a number of prisoners who have arrived in the prison within the last month. In so doing they can be asked about their time in the prison as well as events in any prior places of detention

7.4 (b) Privacy of interviews

Some security measures on the part of the authorities are to be expected, but the privacy of interviews is paramount both for gaining trust and for obtaining reliable information. If the authorities insist on the presence of guards, they should be out of hearing range of the interview. Moreover, the privacy of the interview must also preclude the presence of other prisoners, since it is feasible that other prisoners may inform the authorities on the content of any discussion! Generally, if the interviews are being conducted in a secure location within a prison, then the use of restraints (handcuffs etc) should not be accepted by the visitors. Certainly where any medical examination is concerned this should not be conducted with the person in any form of restraints [see section 3.2 (f)]

7.4 (c) Informing and obtaining consent from prisoners

Information about conditions in custody may be sensitive, and information regarding torture may be even more sensitive, at least where the prisoner is still being held in the place where the torture occurred; so prisoners may be reluctant to reveal such details. Visitors should not assume that prisoners will necessarily trust them. Conversely, some prisoners may have an exaggerated perception of the powers of the visiting team (since they have obtained permission from the government to enter the place of detention which is barred to most outside organisations). Often this translates to a feeling that the visiting team can protect the individual against any future harm, including any harm that may result from raising complaints about their current situation. In some cases the prisoner may think that the team can get them released.

Thus, from the outset, it is vital to explain the purpose, mandate and limitations of the visit and obtain the consent and co-operation of the prisoners, which can be facilitated by the production of booklets or leaflets and

so on. The visiting team has a high degree of responsibility not to cause additional harm to the prisoners through the process of the visit. Thus, explanations of the purpose of the visit should not only highlight the possible benefits, but must also make clear the potential harms, and the consent of the individuals must be obtained before proceeding. The team must use sound judgement in deciding what information, if any, to use and how to use it.

It is important to explain the role of the health professional on the team to the prisoners, which should be to assess the overall conditions and impact on the health of the prisoner population as a whole, and, where relevant to document as many cases of allegations of torture or other ill-treatment as possible. Equally, the health professional should explain their limitations, principal among which is that they are not replacing the existing medical service and not necessarily taking on a therapeutic role (although this should not rule out notifying the prison authorities and seeking treatment for especially grave cases who have not received any attention). Before proceeding,

consent should be obtained to the process. If individuals decline to meet or talk with the team, this decision must be respected, but the team should also be aware that prisoners may have faced intimidation either not to talk, or to portray everything as acceptable or good

7.4 (d) Touring the premises

Wherever possible, before commencing interviews, the team should seek to tour the premises to observe directly the conditions and also to ensure that prisoners are not hidden in far flung parts of the premises. Such a tour should include the cells or barracks, the exercise/recreational areas, the kitchens and dining areas, the toilets and bathrooms, the health service, any workplaces and the areas where family visits take place. If time allows, the health professional on the team should also visit any outside health referral centres since this provides an understanding of the level of health care available to the community, and thus enables the team to determine what an 'equivalent' level of health care is for the prisoners.

7.4 (e) Health services in place of detention

From the point of view of the health services the health professional should make time to talk privately with the prison health staff, in particular the physician, to obtain their perspectives on the running of the health service. Keep in mind that in caring for the prisoner-patient, prison physicians are often faced with professional and ethical dilemmas stemming from clashes between prison security and medical care (see section 3.2 (d), Dual obligations). Part of the discussion may thus involve raising their awareness on the ethical issues, on international standards and on ways to resolve such clashes.

Where torture is the issue, the prison physician may face additional pressures from the authorities in charge either to ignore prisoner complaints, or even to falsify medical reports. There may be no existing mechanisms in the prison system, or even nationally, for the prison physician to obtain support or to raise complaints, or the prison physician may be unaware of their existence. Thus the visiting team may be able to provide information on national and international support and complaint mechanisms or organizations (e.g. National Medical Association; World Medical Association)

7.5 What to do with the information?

Information obtained during a detention visit can be used in varying ways and at different levels of authority from those running the concerned prison, up to the level of the concerned government ministries.

7.5 (a) The use of named or anonymous allegations

In compiling reports or interventions to the authorities responsible for a place of detention the visiting team may include allegations from named or unnamed sources. While allegations from named sources are often seen as more credible, the decision to identify individuals is one that the individual prisoners themselves must make, based on clear explanations by the visitors of the possible benefits and potential risks. It should be made clear that there can be no absolute guarantee against reprisals.

7.5 (b) Compiling and using a report of the visit

At the end of a visit, the team may decide to give immediate verbal feedback and relay specific

issues to the authorities running the prison. Subsequently a report summarizing the findings and discussions could be sent to the prison. Similarly, a report can be sent to either the regional or central prison authority, and/or to the responsible ministry and subsequent meetings held to discuss the issues. Whether any of the information obtained is made public will depend on the agreement reached before entering the prison. Certain visiting bodies, such as the ICRC, have a strict policy of confidentiality concerning detention visits. The international monitoring mechanism of the OPCAT will in principle also operate on a confidential basis, whereas the national mechanism might not

7.5 (c) Repeating the visits

One way to ensure that prisoners are not subjected to harassment or outright reprisals for having talked to outsiders is to visit and interview them again. The interval between visits obviously will depend on the actual risk of harm from the side of the detaining authorities. In order to be able to locate each person effectively and to interview him or her personally about any such reprisals, it is necessary to have a system for collecting and recording personal information so as to ensure reliable identification of the same individuals on subsequent visits. These data may also serve to follow the prisoner throughout their detention and may help to prevent 'disappearances' by checking whether they are present or have been transferred or released. Information on how to contact the individuals if they are released may also be useful should this be needed in the future.

Glossary of Specialized Terms

Report to the Russian Government on the visit to the Russian Federation carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 17 December 2001

Medical Terms:

The Committee visited a large number of places of detention, noting varying degrees of compliance with expected standards. Physical conditions of detention were amongst the focus points of the inspection. As mentioned in this handbook, extremelpoor conditions can be detrimental to the physical and mental health of those in custody.

From the CPT report:

'Cells measuring 7.5 m^2 usually held 3 to 4 prisoners, dormitories measuring 20 m^2 accommodated as a rule between 17 and 20 inmates, and dormitories measuring 33 m^2 held up to 30 inmates. In a number of cells, not every prisoner had his own bed (the most extreme case seen being a cell measuring 20 m^2 which contained 8 beds and was accommodating 25 persons) and inmates took turns to sleep on the available beds or slept on the floor.

'The negative effects of the overcrowding were exacerbated by the fact that cell windows (including those in the section accommodating prisoners with TB) were covered with slatted metal shutters, which severely restricted access to natural light and fresh air. As for artificial lighting - which was left on 24 hours a day - it was poor in many of the cells. The level of hygiene was also dubious: in some cells the delegation saw cockroaches, and prisoners also referred to the presence of mice and rats.'

Auditory hallucinations	The experience of external sounds where there are no external
Axilla	Armpit
Brachial plexus	The nerves running from the spine into the arm
Callus	An area of thickening of bone at the place of healing
Cerebral oedema	Swelling of the brain
Cognitive impairment	Partial impairment of memory, thinking, perception or mood
Depigmentation	Complete loss of pigment from a patch of skin
Haematuria	Blood in the urine
Hyperpigmentation	Increase in pigmentation of a patch of skin
Hypopigmentation	Partial loss of pigment from a patch of skin
Intrusive memories	Involuntary, unpleasant and recurrent memories of an incident
Laceration	A wound in which the skin is torn by blunt force
Medical history	An individual's personal account of a health problem
Medico-legal	Relating to that branch of medicine that assists the courts
Neuropathy	Nerve damage
Oedematous	Swollen
Pathognomonic	A pathological finding that has only one cause
Perianal	Around the anus
Petechiae	Clusters of very small bruises
Psychosomatic symptoms	Apparently physical symptoms that have a psychological cause
Retinal haemorrhage	Bleeding into the back of the eye
Sequelae	The consequences of a medical problem
Striae distensae	Stretch marks of the skin
Subdural bleeding	Bleeding between certain layers of fibrous tissue covering the brain
Tonic-clonic fits	The common form of epileptic convulsions
Urethral meatus	The aperture at the end of the penis through which urine is voided
Vectors of Disease	Agents that can transmit infections

Legal Terms:

Arrest	The act of apprehending a person for the alleged commission of an offence or by the action of an authority.
Asylum	Asylum is sought by individuals who do not wish to return to a country, usually their own, where they are at risk. If granted, they would be allowed to remain in a country which is not their own. This may be temporary or permanent.
Convention	see Treaty
Corroboration	Evidence which supports or confirms the truth of an allegation.
Crimes against humanity	Serious acts, such as torture, committed as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict.
Declaration	A particularly formal resolution, usually of the United Nations General Assembly, which is not as such legally-binding, but sets out standards which states undertake to respect
Deportation	Expulsion from a country.
Derogate	To temporarily suspend or limit.
Detention	Depriving a person of personal liberty except as a result of conviction for an offence.
Domestic law or legal system	National law or legal system; law or legal system which is specific to a particular country.
Enforcement(of obligations)	Making the obligations effective; ensuring that they are respected
Impunity	Being able to avoid punishment for illegal or undesirable behaviour.
Incommunicado detention	Being held by the authorities without being allowed any contact with the outside world
Instrument	A general term to refer to international law documents, whether legally binding or not.
Inter-governmental body	A body or organisation composed of the governmental representatives of more than one country.
Judicial	Relating to the administration of justice or the courts of law.
Legally-binding	If something is legally-binding on a state, this means that the state is obliged to act in accordance with it, and there may be legal consequences if it does not do so.

Monitoring	Seeking and receiving information for the purpose of reporting on a subject or situation.
Non-state actors	Private persons or groups acting independently of the authorities.
Perpetrator	The person who has carried out an act.
Ratification	The process through which a state agrees to be bound by a treaty.
Reparation	Measures to repair damage caused, e.g. compensation.
State Party (to a treaty)	State which has agreed to be bound to a treaty.
Treaty	International law document which sets out legally-binding obligations for states.
Violation (of obligations)	Failure by a state to respect its obligations under international law.
War Crimes	Serious violations of the rules of war, for which the perpetrator can be held criminally responsible.

SOURCE: Michael Peel and Noam Lubell with Jonathan Beynon, **Medical Investigation and Documentation of Torture: A Handbook for Health Professionals**, Human Rights Centre, University of Essex, 2005, with modification.

Available at http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

VIII. ARTICLES ON PSYCHIATRY AND TORTURE

A) Psychiatry and Torture

Daryl Matthews

University of Hawaii, Manoa, HI, USA

I would like to add to Julio Arboleda- Flórez's excellent discussion of the problem of psychiatric participation in interrogations. There is considerable international support for asking psychiatrists and other physicians not only to decline to participate in torture and related practices, but also to speak out vigorously against its use by governments. While medical ethics surely disapproves such practices, they are also widely condemned in other quarters. For example, in its aspirational "Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment", the United Nations General Assembly, after asserting that "no person under any form of detention or imprisonment shall be subject to torture or to cruel, inhuman, or degrading treatment or punishment", adds in a note: "The term 'cruel, inhuman or degrading treatment or punishment' should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time" (1). In addition, the Body of Principles requires that "no detained person while being interrogated shall be subject to violence, threats or methods of interrogation which impair his capacity of decision or his judgment" (1). Psychiatrists are in a unique position to understand and communicate the importance of these principles and should denounce torture strongly in every possible venue. As Sagan and Jonsen (2) observed, because the medical skills used for healing can be maliciously perverted "with devastating effects on the spirit and the body", it is "incumbent upon the medical profession and upon all of its practitioners to protest in effective ways against torture as an instrument of political control". This is even more urgently true today than when it was written thirty years ago.

References

1. Office of the United Nations High Commissioner for Human Rights. Body of principles for the protection of all persons under any form of detention or imprisonment.
New York: United Nations, 1988.

2. Sagan LA, Jonsen A. Medical ethics and torture. N Engl J Med 1976;294:1427.

Source:

World Psychiatry (Official Journal of the World Psychiatric Association), Volume 5, No. 2, June 2006. http://www.wpanet.org/home.html

Pergamon

Journal of Anxiety Disorders, Vol. 9, No. 4, pp. 339–350, 1995

0887-6185/95 $9.50 + .00

0887-6185(95)00014-3

Severity of Trauma as Predictor of Long-term Psychological Status in Survivors of Torture

METIN BAŞOĞLU, M.D., PH.D.

Institute of Psychiatry, University of London

MURAT PAKER, M.D.

New School for Social Research, New York

Abstract — Severity of trauma as a predictor of long-term psychological functioning was examined in 55 tortured political ex-prisoners in Turkey. The assessments included semistructured interviews and measures of anxiety, depression, and posttraumatic stress disorder. The severity of torture was assessed by measures of number of types of torture, number of exposures to torture, duration of captivity, and perceived distress. The survivors reported a mean of 23 different forms of torture and a mean total of 291 exposures to torture during their captivity. Despite severity of trauma, the number of exposures to torture did not predict posttorture psychological problems, whereas ratings of perceived distress did. Implications of these findings for theory and classification of psychological trauma and for legal practices concerning torture survivors are discussed.

INTRODUCTION

Study of torture not only serves a useful social and political purpose by promoting awareness of this human rights problem but can also provide valuable

The project was supported in part by the Bromley Trust in the United Kingdom. The authors also wish to acknowledge the support of the Istanbul chamber of Medicine, the Turkish Human Rights Association, the Human Rights Association of Istanbul, and the Turkish Medical Association in conducting the study.

Drs. Özgün Taşdemir, Erdoğan Özmen, Cem Incesu, Doğan Şahin, and Nuşin Sarimurat contributed to the collection of the data.

We are deeply grateful to all study participants, who fully appreciated the need for scientific study in this field and its value for the human rights cause.

Reprint requests should be sent to Metin Başoğlu, MD, PhD, Institute of Psychiatry, 99 Denmark Hill, London SE5 8AF, England.

insights into the psychological processes of traumatization. Başoğlu and Mineka (1992), in their review of experimental models of anxiety, depression, and posttraumatic stress, have suggested that the human experience with probably the closest parallels to experimental models in animals is the experience of humans undergoing torture. However disturbing these parallels might be, a better understanding of the ever increasingly sophisticated (and psychological) forms of torture in the world today and their effects on individuals is essential in recognizing and combatting the problem. Such understanding can also be useful in identifying principles of effective treatment, not only for survivors of torture, but also for survivors of other traumas in general.

Severity of traumatic stressor as a determinant of subsequent stress responses has received much attention in work with trauma survivors. It was found to be a significant predictor of posttraumatic stress disorder (PTSD) in most studies of combat veterans (Foy, Sipprelle, Rueger, & Carroll, 1984; Foy, Edward, & Donahue, 1987; Foy & Card, 1987; Laufer, Gallops, & Frey-wouters, 1984; Breslau & Davis, 1987; Green & Berlin, 1987; Green, Lindy, Grace, & Gleser, 1989; Green, Grace, Lindy, Gleser, & Leonard, 1990; Speed, Engdahl, Schwartz, & Eberly, 1989). A similar dose-effect relationship has been noted in victims of rape (Steketee & Foa, 1987), volcanic eruption (Shore, Tatum, & Vollmer, 1986), fire disaster (Green, Grace, & Gleser, 1985), and urban violence (Pynoos et al., 1987), and in battered women (Kemp, Rawlings, & Green, 1991).

Few investigations have studied the stressor dose-response relationship in torture survivors. Although some studies of former POWs (Miller, 1992; Speed et al., 1989) have examined the impact of torture among other stressful events during captivity, no study has yet examined the effects of torture itself at different levels of severity.

Social and political environments in which torture is widespread are also characterized by other potentially traumatic forms of repression and violence. In examining the impact of torture, therefore, the effects of related stressors have to be taken into account. As most studies of torture survivors have been uncontrolled and involved refugees (Goldfeld, Mollica, Pesavento, & Faraone, 1988; Somnier, Vesti, Kastrup, & Genefke, 1992), definitive conclusions concerning the long-term effects of torture per se are not possible. No study has yet attempted to examine the relative impact of torture, controlling for other stressors during and after the trauma.

The present report is based on a controlled comparison of 55 tortured and 55 nontortured political activists in Turkey (Başoğlu et al., 1994). This study avoided some of the methodological problems of earlier studies by using closely matched controls, standard assessments, and established diagnostic criteria. We selected a nonrefugee group to avoid the confound of refugee status. The study found greater levels of traumatization in torture survivors relative to controls, independent of other stressors during and after the period during which torture took place.

In the present report we examined the effect of *severity* of torture on subsequent psychological functioning. We tested the following hypothesis: long-

term psychological responses to torture in torture survivors will be predicted by the severity of trauma as defined by the number of types of torture endured, the frequency of exposures to torture, the duration of captivity, and the perceived severity of torture.

This report focuses on the severity of torture as a predictor of long-term psychological functioning. An examination of all predictors on which data are available is reported elsewhere (Başoğlu, Paker, Taşdemir, Özmen, & Şahin, in press).

METHOD

Details of the method and procedures were reported in a previous article (Başoğlu et al., 1994) and will therefore only be summarized here. The study was announced in the media through articles in newspapers and political journals. Survivors of torture, regardless of their political allegiance, were invited to participate in the study. The study group consisted of 55 left-wing political activists who had been tortured during detention and/or imprisonment in the late 1970s and throughout the 1980s in Turkey. Fifty survivors were referred to the study by human rights organizations in Istanbul and five were self-referred. All study participants signed a consent form that explained the aims of the study in detail. Strict confidentiality was emphasized. Of the 58 referrals, none refused to be interviewed at all, though three failed to attend the second interview. The account of torture was validated by independent information from the referring source in 50 survivors. The interviews were conducted by two psychologists and four psychiatrists trained in the use of semistructured instruments.

Assessment

Information on personal history and details of prison and torture experience were obtained using Semi-structured Interview for Survivors of Torture (SIST) based in part on Jackson Interview Form (Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985) and Exposure to Torture Scale, part of SIST.

Psychiatric status was assessed by using the Structured Clinical Interview for DSM-III-R (SCID; Spitzer & Williams, 1983). Other measures included: Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Standardized Turkish version, Hisli, 1987), State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970; Standardized Turkish version, Öner & LeCompte, 1982).

In addition to the clinical ratings above, Number of PTSD symptoms since trauma (based on the SCID) was selected for analysis. The SCID diagnosis of PTSD was not used as a categorical variable (present/absent) to avoid loss of information and statistical power (only 10 survivors had PTSD).

Predictor variables: measures of torture severity. These measures were derived from the Exposure to Torture scale, which consists of a list of forms of

torture commonly used throughout the world. This scale was devised for work with torture survivors to improve the reliability and validity of the information elicited about past torture experience. A structured interview facilitates recall of the details of past torture experience and thereby elicits more reliable information than do open-ended questions.

The scale provides information on forms of torture endured, number and duration of exposures, and subjective distress ratings related to each form of torture (1 = no/minimal distress, 4 = extremely distressing). For example, if a survivor reports electrical torture, the number of times of exposure to electrical torture, duration of exposures, and the survivor's rating of the distress he/she experienced during this form of torture are recorded.

Three measures of torture severity were derived from the scale: (a) *N* of forms of torture(total number of forms of torture reported by the survivor), (b) *N* of exposures to torture (total number of exposures to all forms of torture), and (c) Total Distress score (sum of all distress ratings). Duration of specific forms of torture was not included in the analyses, as data were not available for all forms of torture. However, duration of captivity (total time spent in detention and imprisonment) was included as an additional measure of torture severity since the survivors' accounts indicated that torture was routine throughout the period of detention and imprisonment. Furthermore, there was a significant correlation between duration of captivity and total number of exposures to torture ($r = .49$, $p < .001$). Thus, longer captivity meant more torture.

Data Analysis

Pearson correlation analyses examined the relationship between measures of torture severity and clinical ratings. Multiple regression analyses (stepwise) examined which torture severity measures predicted posttrauma symptoms.

RESULTS

Sample Characteristics

Twenty-five (45%) survivors were female and 30 were male. The mean age was 31 (*SD* 5.5). Twenty-six (47%) survivors were married. All survivors had at least one detention, while 89% had at least one imprisonment. The survivors had been detained for a mean 39 days (*SD* 31, range 1–135) and imprisoned for mean 48 months in total (*SD* 56, range 0–164). The mean time since release from prison was 41 months (*SD* 43, range 2–143). Last incident of torture had occurred a mean of 61 months ago (*SD* 45, range 3–145).

Before captivity, 84% of the survivors were fairly or fully committed to a political cause; only 16% were somewhat or not at all committed, being accidentally involved in political activity. All survivors were fairly well informed about the practice of torture in their country prior to its occurrence.

Only two survivors had current major depression. Eighteen (33%) survivors had PTSD at some stage after the torture, while 10 (18%) had current PTSD.

Mean number of PTSD symptoms since last torture was 6 (*SD* 4.4). The symptoms were moderately severe; no survivor had severe PTSD. Mean anxiety and depression ratings were within normal range.

Severity of Torture

The forms of torture and the total number and duration of exposures are shown in Table 1.

Survivors reported a mean of 23 (*SD* 7, range 9–41) different forms of torture. Fifty-one percent of the survivors were subjected to 25 different forms of

TABLE 1

FORMS OF TORTURE: FREQUENCY, TOTAL NUMBER, AND DURATION OF EXPOSURE

Forms of torture reported	% of survivors	Total N of exposures Mean (SD)	Range	Total duration Mean (SD)
Verbal abuse*	100	–	–	–
Beating	100	43 (43)	1-100	–
Blindfolding	98	23 (26)	1-70	–
Alternating gentle/harsh treatment	93	19 (19)	1-60	–
Threats of further torture	85	30 (22)	1-60	–
Forced standing	97	7 (9)	1-25	7.3 hrs (8.2)
Prevention of personal hygiene	82	16 (20)	1-45	104 days (258)
Pulling by hair	78	4 (3)	1-10	–
Electrical torture	78	10 (10)	1-35	19 mins (17)
Witnessing torture	74	25 (30)	1-70	5.3 hrs (7)
Threats of death	73	39 (32)	1-70	–
Stripping naked	71	15 (19)	1-60	2.7 hrs (4.2)
Prevention of urination/defecation	71	22 (25)	1-60	–
Isolation	67	5 (11)	1-60	46 days (94)
Sleep deprivation	65	3 (4)	1-13	34 days (88)
Restriction of movement	62	3 (4)	1-15	20 days (43)
Falaqa	62	12 (12)	1-35	29 mins (25)
Deprivation of medical care	62	9 (12)	1-32	211 days (383)
Exposure to extreme heat or cold	60	9 (12)	1-41	5.9 days (9.1)
Threats of rape	58	5 (6)	1-18	–
Denial of privacy	56	7 (9)	1-25	60 days (213)
Threats against family	53	19 (13)	1-30	–
Infested surroundings	53	3 (3)	1-10	–
Food deprivation	51	3 (4)	1-20	5 days (4)
Hanging by wrists	51	8 (8)	1-25	20 mins (12)
Exposure to loud music	45	22 (26)	1-60	7.7 hrs (7.4)
Water deprivation	44	5 (8)	1-30	2.5 days (2)
Cold showers	42	8 (11)	1-50	15 mins (14)
Blows on ears	40	4 (6)	1-20	–
Sham executions	38	3 (2)	1-10	–
Forced standing with weight on	33	7 (6)	1-15	29 mins (47)
Fondling of genitals	31	5 (7)	1-20	–
Asphyxiation	24	3 (2)	1-9	–
Submersion in water, feces, vomit	16	3 (3)	1-10	9 mins (11)

(continued on next page)

TABLE 1—*Continued*

Forms of torture reported	% of survivors	Total N of exposures Mean (SD)	Range	Total duration Mean (SD)
Exposure to bright light	13	1 (.9)	1-3	44 mins (39)
Excrement in food	13	9 (8)	2-20	--
Burning	9	3 (2)	1-6	--
Rope bondage	9	9 (10)	2-20	24 mins (9)
Throwing of feces/urine at detainee	9	1 (.9)	1-3	--
Stretching of extremities	6	2 (1)	1-3	6 mins (6)
Needles under toenails or fingernails	6	1 (.6)	1-3	--
Twisting testicles	6	7 (6)	2-13	--
Rape	4	1 (0)	1-1	--
Others	53	3 (3)	1-12	--

* Information not available as reliable estimate of N of exposures could not be made

torture. The mean total number of exposures was 291 (*SD* 222) and ranged between 24 and 822. The torture events took place during mean 47 months of captivity (*SD* 56, range 1 day–166 months).

The "others" category in Table 1 includes less frequent forms of torture, each reported by 1 or 2 survivors. Examples were attempts to insert an object into anus/vagina, being forced to torture others, witnessing torture of family, and sexual advances.

Social Support

In assessing social support (psychological, economic, and legal), the survivor's own evaluation and degree of satisfaction was taken into account. During captivity, 51 (93%) of the survivors received very much/much support from at least one group of significant others (spouse, relatives, friends). The respective figures for postimprisonment phase were 47 (86%).

Correlation Between Stress Measures and Clinical Ratings

Table 2 shows the Pearson correlation coefficients between the stress measures and clinical ratings.

Only the rating of perceived distress (Total Distress score) significantly correlated with number of PTSD symptoms. Duration of captivity showed negative correlations with all clinical ratings, reaching significance on STAI-State. Longer imprisonment thus related to less anxiety at assessment.

Correlations Between Measures of Torture Severity

Total Distress score showed a highly significant correlation with number of forms of torture ($r = .81$, $p < .001$). This was because the former was derived from the latter by summing up the distress scores for all forms of torture.

TABLE 2

CORRELATIONS BETWEEN MEASURES OF SEVERITY OF TORTURE AND CLINICAL RATINGS*

	N of forms of torture	N of total exposures	Total Distress score	Duration of captivity
N of PTSD symptoms	.25 (.07)	.04 (.80)	.42 (.001)	-.16 (.24)
Beck Depression	-.14 (.30)	-.08 (.58)	.08 (.56)	-.26 (.06)
STAI-State Anxiety	-.23 (.09)	-.19 (.17)	-.07 (.61)	-.32 (.02)

* p values in parentheses

Despite this high correlation, only Total Distress score correlated significantly with the number of PTSD symptoms ($r = .42$, $p < .001$), though a trend towards significance was noted for number of forms of torture ($r = .25$, $p = .07$). This finding suggested that the traumatic impact of torture was mediated through subjective appraisal of events rather than by mere cumulative effects of repeated exposures.

The mean time since last torture did not significantly correlate with any of the clinical measures. The only exception was STAI-State ($r = -.30$, $p < .05$), which may be due to chance. Severity of current symptoms was thus not related to the length of time since torture.

Multiple Regression Analyses

Multiple regression analyses were performed (stepwise) using all 4 stress measures as independent variables and each clinical rating in turn as the dependent variable. Stepwise method checks repeatedly whether (a) any variable not in the equation should be entered, according to the criterion *probability of F-to-enter* (PIN); and (b) any variable in the equation should be removed, according to the criterion *probability of F-to-remove* (POUT). The values used for PIN and POUT were .05 and .10, respectively.

Using number of PTSD symptoms as the dependent variable, only two variables entered the equation (percentage of variance explained in parentheses): Total Distress score (16%, $\beta = .42$, $t = 3.4$, $p < .001$) and duration of captivity (7%, $\beta = -.28$, $t = -2.3$, $p < .05$). Thus, only perceived severity of torture and duration of captivity predicted number of PTSD symptoms. Longer duration of captivity related to fewer PTSD symptoms. Using the Beck Depression Inventory as the dependent variable, no variables entered the equation. In the third regression analysis duration of captivity explained 8% of the variance in STAI-State ($\beta = -.32$, $t = -2.43$, $p < .05$). Longer duration of captivity related to less subsequent anxiety.

In summary, our hypothesis was only partially supported in that PTSD symptoms were predicted by the perceived severity of torture but not by the total number of exposures to torture.

DISCUSSION

The findings of the present study need to be interpreted together with those of a previous report (Başoğlu et al., 1994) that showed that severe torture induced moderately severe stress symptoms and no anxiety or depression in our study group. Eighteen of the 55 survivors had PTSD some time after the trauma and only 10 had current PTSD. In human research on the learned-helplessness phenomenon (Mineka & Kelly, 1989), exposure to uncontrollable stressors of a much milder nature was sufficient to induce anxiety or depression. Furthermore, many people are severely affected by much milder traumas. Several factors, discussed below, may account for this finding.

Unpredictability and uncontrollability of stressors play an important role in the origins and maintenance of fear and anxiety (Mineka & Kelly, 1989). Torture was neither a totally unpredictable nor uncontrollable event for most survivors in our study. They had prior knowledge of what it involved and were psychologically prepared for its occurrence. They may have also used effective coping strategies to avoid loss of control during torture. Effective coping combined with repeated exposures to torture may have immunized them against traumatic stress induced by torture. Prior learning that one has control over aversive stimulation can immunize the organism against the later effects of exposure to uncontrollable stressors (Başoğlu & Mineka, 1992).

In addition, survivors had no difficulty in finding an explanation for their experience, a factor important in emotional processing of the trauma (Foa, Steketee, & Rothbaum, 1989). They were clearly aware of the purpose of torture as a means of political repression and knew exactly why they were targeted for this kind of treatment. Most were highly committed to their political cause and regarded torture as a price they had to pay in their struggle for a better world.

Strong social support may also have provided some protection from the traumatic effects torture. Without such protection, symptom intensities might have been higher than those observed in our study. This is consistent with the findings of other studies that point to the importance of posttrauma social support (Barrett & Mizes, 1988; Foy, Resnick, Sipprelle, & Carroll, 1987; Kadushin, Boulanger, & Martin, 1981; Keane et al., 1985; Solomon, Mikulincer, & Hobfol, 1987)

Longer stay in prison appeared to be a protective factor against anxiety, depression, and PTSD. While duration of captivity and PTSD were unrelated in some studies of POWs (Thygesen, Hermann, & Willanger, 1970; Speed et al., 1989) and concentration camp survivors (Matussek, 1975), no study found longer captivity to be related to better psychological health. This finding may be explained by the availability of opportunities for emotional support and sharing of traumatic experiences with friends and comrades in prison. In addition, survivors were able to transform their captivity into a meaningful experi-

ence by ardently continuing their political struggle in the prison at a time when most political activities were banned in the country.

There is general agreement in the literature that the severity of trauma is an important factor in the etiology of PTSD (Foy, Edward et al., 1987; Lindy, Green, & Grace, 1987). How can our results be reconciled with the findings of previous studies? The most likely explanation concerns the nature of our sample. Our sample may have been different from those in most other studies in having the protective characteristics discussed above. Cross-cultural differences in the perception of trauma may also have played a role in determining psychological responses to torture. Some survivors, for example, who were beaten up by the police during interrogation did not regard their treatment as torture. Furthermore, many torture methods, which would be regarded as highly traumatic by the ordinary person, were rated as only slightly or moderately stressful by the survivors. This is consistent with other observations that what is perceived as torture varies widely across cultures (Mollica & Caspi-Yavin, 1992).

In addition, there was considerable within-group variability in the perception of events as stressful. Subjective distress ratings indicated that the survivors differed in their perception of particular torture events as traumatic. Thus, summing up all potentially stressful events without regard to their subjective impact may not yield a reliable index of trauma severity. The trauma survivors in other studies may have been more homogeneous with respect to their perception of events as traumatic, in which case other measures of trauma severity (e.g., number of events and frequency of exposures) would be expected to parallel subjective distress ratings more closely.

A problem concerning the measures of trauma severity is the possibility of, distortions in retrospective recall. Although the interview questions clearly referred to how the survivors felt about torture *then* and not at the time of assessment, there may still have been problems in the recall of the nature and frequency of torture events. Depression at the time of assessment, however, seems unlikely to have affected retrospective evaluaton of torture experience, since the survivors were not depressed and anxiety/depression scores did not significantly correlate with subjective distress ratings.

That only perceived distress predicted long-term psychological functioning supports the view that trauma may be a "threshold" variable rather than a cumulative or additive variable (Zeiss & Dickman, 1989). Indeed, beyond a certain threshold, increased duration and frequency of torture appeared to have no additional impact. This finding suggests that nonlinear relationships may exist between trauma and its impact, a point that could be investigated in further research efforts.

The association between perceived distress during torture and subsequent psychological problems may in part reflect vulnerability to traumatic stress. The latter may have enhanced the subjective impact of torture in some survivors. This explanation is also consistent with the finding of an association between family history of psychiatric illness and posttorture psychological functioning (Başoğlu et al., 1994).

Our findings may also have implications for legal practice concerning torture survivors. This important issue, although not directly related to the main focus of the present report, deserves attention here. The definition and severity of torture often become important issues in legal cases involving political asylum applications and compensation claims. Often important decisions are influenced by the assumption that the degree of psychological disability reflects the severity of the trauma. Asylum applicants, for instance, can make a stronger case if they can evidence the severity of their torture.

This assumption may lead to problems in decisions concerning two groups of survivors: those who have survived severe trauma with minimal or no sequelae and those who are severely traumatized as a result of apparently mild trauma. The first group may have difficulty evidencing past torture while the second may not be able to provide a convincing account for the severity of disability. Both groups may come across as malingerers for different reasons. Subjective aspects of the trauma should be given due consideration to avoid errors in the assessment of such cases.

An important limitation of our study is the select nature of our sample. Due to referral biasses, survivors with greater resilience to traumatic stress and better psychological health may have been overrepresented in our study group. This may have led to an underestimation of the effects of torture and obscured a possible relationship between severity of torture and subsequent stress responses. Further research should also involve nonpolitical survivors with no prior psychological preparedness for torture.

REFERENCES

Barrett, T. W., & Mizes, J. S. (1988). Combat and social support in the development of posttraumatic stress disorder in Vietnam veterans. *Behavior Modification*, 12(1), 100–115.

Başoğlu, M., & Mineka, S. (1992). The role of uncontrollability and unpredictability of stress in the development of posttorture stress symptoms. In M. Başoğlu (Ed.), *Torture and its consequences: Current treatment approaches*. New York: Cambridge University Press.

Başoğlu, M., Paker, M., Paker, Ö., Özmen, E., Marks, I. M., Incesu, C., Şahin, D., & Sarimurat N. (1994). A comparison of tortured with matched nontortured political activists in Turkey. *American Journal of Psychiatry*, **151**, 76–81.

Başoğlu, M., Paker, M., Taşdemir, Ö., Özmen, E., & Şahin, D. (1994). Factors related to long-term traumatic stress responses in survivors of torture in Turkey. *Journal of the American Medical Association*, **272**(5), 357–363.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, **4**, 561–571.

Breslau, N., & Davis, G. C. (1987) Posttraumatic stress disorder: The etiologic specificity of wartime stressors. *American Journal of Psychiatry*, **144**, 578–583.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of posttraumatic stress disorder. *Behavior Therapy*, **20**, 155–176.

Foy, D. W., Sipprelle, R. C., Rueger, D. B., & Carroll, E. M. (1984). Etiology of posttraumatic stress disorder in Vietnam veterans: Analysis of premilitary, military, and combat exposure influences. *Journal of Consulting and Clinical Psychology*, **52**, 70–87.

Foy, D. W., & Card, J. J. (1987). Combat-related posttraumatic stress disorder etiology: Replicated findings in a national sample of Vietnam-era men. *Journal of Clinical Psychology*, **43**, 28–31.

Foy, D. W., Edward, M. C., & Donahoe, C. P. (1987). Etiological factors in the development of PTSD in clinical samples of Vietnam combat veterans. *Journal of Clinical Psychology*, **43**, 17–27.

Foy, D. W., Resnick, H. S., Sipprelle, R. C., & Carroll, E. M. (1987). Premilitary, military, and postmilitary factors in the development of combat-related posttraumatic stress disorder. *The Behavior Therapist*, **10**, 3–9.

Goldfeld, A. E., Mollica, R. F., Pesavento, B. H., & Faraone, S. V. (1988). The physical and psychological sequelae of torture: Symptomatology and diagnosis. *Journal of the American Medical Association*, **259**, 2725–2729.

Green, B. L., Grace, M. C., & Gleser, G. C. (1985). Identifying survivors at risk: Long-term impairment following the Beverly Hills Supper Club Fire. *Journal of Consulting and Clinical Psychology*, **53**, 672–678.

Green, M. A., & Berlin, M. A. (1987). Five psychosocial variables related to the existence of posttraumatic stress disorder symptoms. *Journal of Clinical Psychology*, **43**, 643–649.

Green, B. L., Lindy, J. D., Grace, M. C., & Gleser, G. C. (1989). Multiple diagnosis in posttraumatic stress disorder. The role of war stressors. *Journal of Nervous and Mental Disease*, **177**, 329–335.

Green, B. L., Grace, M. C., Lindy, J. D., Gleser, G. C., & Leonard, A. (1990). Risk factors for PTSD and other diagnoses in a general sample of Vietnam veterans. *American Journal of Psychiatry*, **147**, 729–733.

Hisli, N. (1987). Beck Depresyon Envanterinin geçerliliği üzerine bir çalişma (A study on the validity of Beck Depression Inventory). *Turkish Journal of Psychology*, **6**(22), 118–122.

Kadushin, C., Boulanger, G., & Martin, J. (1981). Medical and psychiatric treatment policy and practice in Vietnam. *Journal of Social Issues*, **50**, 180–192.

Keane, T. M., Scott, W. O., Chavoya, G. A., Lamparski, D. M., & Fairbank, J. A. (1985). Social support in Vietnam veterans with posttraumatic stress disorder: A comparative analysis. *Journal of Consulting and Clinical Psychology*, **53**, 95–102.

Kemp, A., Rawlings, E. I., & Green, B. L. (1991). Post-traumatic stress disorder (PTSD) in battered women: A shelter sample. *Journal of Traumatic Stress*, **4**(1), 137–148.

Laufer, R., Gallops, M., & Frey-Wouters, E. (1984). War stress and trauma: The Vietnam experience. *Journal of Health and Social Behavior*, **25**, 65–85.

Lindy, J. D., Green, B. L., & Grace, M. C. (1987). The stressor criterion and posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, **175**, 269–272.

Matussek, P. (1975). *Internment in concentration camps and its consequences*. New York: Springer-Verlag.

Miller, T. W. (1992). Long-term effects of torture in former prisoners of war. In Başoğlu, M. (Ed.), *Torture and its consequences: Current treatment approaches*. New York: Cambridge University Press.

Mineka, S., & Kelly, K. (1989). The relationship between anxiety, lack of control and loss of control. In A. Steptoe & A. Appels (Eds.), *Stress, personal control and health*. New York: John Wiley & Sons, Inc.

Mollica, R., & Caspi-Yavin, Y. (1992). Overview: The assessment and diagnosis of torture events and symptoms. In M. Başoğlu (Ed.), *Torture and its consequences: Current treatment approaches*. New York: Cambridge University Press.

Öner, N., & LeCompte, A. (1982). *State-trait anxiety inventory manual*. Istanbul: Bosphorus University Publications.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and posttraumatic stress in school-age children. *Archives of General Psychiatry*, **44**, 1057–1063.

Shore, J. H., Tatum, E. L., & Vollmer, W. M . (1986). Evaluation of mental effects of disaster, Mount St. Helens eruption. *American Journal of Public Health*, **76** (Suppl.), 76–83.

Solomon, Z., Mikulincer, M., & Hobfol, S. (1987). Objective versus subjective measurement of stress and social support: Combat-related reactions. *Journal of Consulting and Clinical Psychology*, **55**, 577–583.

Acta Psychiatr Scand 2002: 106 (Suppl. 412): 30–36
Printed in UK. All rights reserved

ACTA PSYCHIATRICA SCANDINAVICA
ISSN 0001-690X

Psychological impact of torture: a 3-month follow-up of mass-evacuated Kosovan adults in Sweden. Lessons learnt for prevention

Ekblad S, Prochazka H, Roth G. Psychological impact of torture: a 3-month follow-up of mass-evacuated Kosovan adults in Sweden. Lessons learnt for prevention
Acta Psychiatr Scand 2002: 106 (Suppl. 412): 30–36.

Objective: To study the impact of torture on symptomatology among mass displaced adults.
Method: A sample (total 131; 70 females, 61 males) of mass displaced adults from Kosovo, in Sweden, completed 3 months after a baseline study on trauma experiences and perceived symptoms, self-rated instruments measuring psychiatric symptoms, aggression and coping.
Results: Torture is associated with poor coping (manageability); depression, anxiety and aggression are associated with post-traumatic stress disorder. All psychiatric symptoms and poor coping (but not aggression) are associated with being female. Limitations of the study include a relatively small sample. Ongoing trauma and stress before repatriation may also influence the responses. Several lessons learnt for prevention are discussed.
Conclusion: Anger and hostility are important consequences of torture. Further research is necessary to understand the associations among coping strategies, psychiatric symptoms, aggression, torture experience and gender over time after repatriation or applying for asylum.

S. Ekblad[1,2], H. Prochazka[3], G. Roth[2]

[1]National Institute of Psychosocial Factors and Health, Stockholm, Unit for Immigrant Environment and Health, Sweden, [2]Section of Psychiatry, Department of Neurotec, Karolinska Institutet, Stockholm, Sweden and [3]Department of Psychiatry, Institute of Clinical Neuroscience, Sahlgrenska University Hospital, Sweden

Key words: trauma; torture; mental health; depression; aggression; PTSD; screening; Kosovar Albanian; refugees

Sonja Ekblad, Associate Professor, Head, Unit for Immigrant Environment and Health, National Institute of Psychosocial Factors and Health, Box 230, SE-171 77 Stockholm, Sweden

This paper, in its preliminary version, was read at the 2nd European Congress on Violence in Clinical Psychiatry symposium 'Violence as public health and victims' perspective', Stockholm, Sweden, 28–30 June 2001

Introduction

The past decade has seen a substantial increase in scientific knowledge relevant to understanding refugee mental health. Recent large-scale epidemiological studies of refugee populations have confirmed the high prevalence of major depression and post-traumatic stress disorder (PTSD) in Western (e.g. Bosnian) and non-Western (e.g. Cambodian and Bhutanese) refugee communities. These findings are consistent with the high prevalence of psychiatric disorders found among refugee patients in clinical treatment in countries of resettlement (for a review, see 1).

The literature shows that persistent consequences of war trauma lead not only to the symptomatic patterns now identified as PTSD (for a review, see 2), but that trauma also affects their personality, behaviour and interpersonal functioning. Furthermore, women are identified as a risk group for psychological distress (3). One of the negative consequences of trauma experiences, especially torture, has been clinically observed as increased aggression manifested both as aggressive behaviour and as other forms of covert aggression.

Mass displaced persons who encounter mental health challenges may also be understood within the context of their resilience and coping capacity. Marks et al. (4) have reviewed dimensions of personality and illness and find that 'stress is only likely to have a strong effect on susceptibility to illness among individuals who score low on internal locus of control, self-efficacy, hardiness and sense of coherence and who have a low level of perceived social support' (4, p. 116).

During the mass displacement from the Kosovo province, the psychological impact of such emergency situations has been a neglected issue. During the mass displacement, the refugees from the Kosovo province had to come to terms with emotional reactions towards earlier and new life events. A recent study by Lopes et al. (5) of mental

health, social functioning and attitudes of Kosovar Albanians following the war in Kosovo, showed that high percentages of both men and women had strong feelings of hatred and revenge. Such feelings can lead to psychiatric symptoms such as depression, anxiety and PTSD symptoms but also to overt aggressive behaviour causing deep distress and contributing to major public health problems, such as poor coping strategies.

The aim of this study was (i) to explore the impact of trauma on depression, anxiety, aggression, PTSD symptoms and coping strategies in a follow-up study 3 months after the baseline; (ii) to distinguish possible variations in self-reported depression, anxiety, PTSD symptoms and aggression between sexes, and in relation to coping; and (iii) to explain the value of early assessment of trauma amongst mass displaced groups.

Context

When NATO began bombing Yugoslavia on 24 March 1999, the systematic expulsion of ethnic Albanians created a humanitarian nightmare. Europe's poorest country, Albania, was currently hosting more than 433 800 refugees. The Swedish Government decided to take in 5000 refugees under the Humanitarian Evacuation Programme between April and June, and the refugees were to be given temporary residence permits valid for 11 months. By 7 June 1999, 2930 had arrived. In this context, the Swedish Migration Board, at the end of May 1999, approved a project by the first author concerning current medical, psychological and social needs among 400 adult Kosovars newly arrived in Sweden. A separate report from the project is published elsewhere (6).

Material and methods

Study population

In the first step (baseline of the project) 402 Kosovars, about one in five, in the age range 18–65 years were randomly selected from the airline passenger lists. These Kosovars were supposed to stay in four of the five centres (Northern, Western, Central and Southern Regions) of the Swedish Migration Board. Participation in the study was voluntary and informed consent was obtained before participation. The number of participants leaving before the start of the baseline was 59 (15%). Of the remainder (343) 218 participated at the baseline (64% response rate). Twenty-seven participants (8%) did not wish to participate, seven participants (2%) were too sick to participate, two were children and too young to be included in the study and the rest (89, 26%) had repatriated before the baseline study was completed. There was a slightly higher percentage of women (N 122, 56%) compared with men ($N = 96$, 44%) in the baseline study. Due to the limitations of no background data being available via the passenger list, it was impossible to do any dropout analysis.

The baseline study began in August–September, 1999, after the Swedish Migration Board assistants and interpreters, who were to interview participants at the centres, had undergone a 1-day training programme. Communication between the project group and the field was maintained by a contact person, from each of the four regions, who was responsible for contacting the assistants during the study.

Between the baseline and the 3-month follow-up, 38 participants (17%) of the 218 who participated in the baseline had repatriated. Of the remaining 180, 131 (70 women and 61 men) aged 18 65 years participated in the first follow-up, 3 months after the baseline giving a response rate of 73% (i.e. percentage of participants out of available subjects in the follow-up study). Forty-nine participants were non-respondents at this follow-up (43 participants could not be located, two participants were visiting Kosovo at the time of the follow-up, four participants were too ill to participate).

Screening tools

The information and questions in the instruments were translated according to the standards of cross-cultural research (7). All instruments, back-translated into Albanian, used in this study were designed as self-report questionnaires. However, in cases of poor education, the questions were read aloud by assistants and interpreters of the Swedish Migration Board. The interviews were conducted at the centres and took about 1–2 h. Prior to the interviews, each respondent was read a letter (in Albanian) of informed consent that indicated the voluntary nature of participation and guaranteed strict confidentiality. Informed consent procedures and study design were approved by the Ethics Committee at the Karolinska Institutet (KI 99–245) in Stockholm.

Trauma exposure. The screening instrument 'Hälsobladet' (in Swedish) was developed by Ekblad et al. (8) for newly arrived refugees in the introduction phase in the community and includes 15 questions about stress-symptoms and trauma

exposure. Responses are 'yes' or 'no' to each item. In this study we used the question about experience of exposure to torture (for more details, see 6).

Instrument for self-rated depression and anxiety. The Hopkins Symptom Checklist (HSCL-25) includes a 15-item scale of depressive symptoms, and a 10-item scale of anxiety symptoms. This instrument has proved to be internally consistent and valid for measuring depression and anxiety in different refugee groups (for a review see 9). The instrument has also been used among immigrant psychiatric outpatients in Sweden (10).

Instrument for self-rated aggression, AQ-RSV. The Swedish version of the AQ, AQ-RSV (Aggression Questionnaire, Revised Swedish Version) standardized on a normal Swedish population was used (11). The 29 items measure four aggression factors: hostility (eight items), anger (seven items), verbal aggression (five items) and physical aggression (nine items). These items are arranged in a randomized order and the original 5-point Likert scale was reduced in the AQ-RSV to four scale steps (from 1 = 'least characteristic' to 4 = 'most characteristic'). This adaptation showed no evident effect on the correlation analyses between the Swedish and the American data. Further advantages of this adjustment are avoidance of neutral answers and the possibility to compare results with other personality inventories.

The trauma symptoms section of the Harvard Trauma Questionnaire (ptsd-HTQ). The Harvard Trauma Questionnaire (HTQ) is a structured interview and consists of four parts; traumatic events (Part 1), personal description (Part 2), damage to head (Part 3) and trauma symptoms (Part 4). Each participant reads a list of 30 symptoms and is asked to report the extent to which each symptom bothered him/her within the past week based on a four-point scale (1–4), ranging from 'not at all' (1), 'a little' (2), 'quite a bit' (3) to 'extremely' (4). The first 16 of the 30 symptoms reflect DSM criteria for PTSD, and were included in this analysis (ptsd-HTQ > mean 2.5 of the 1–16 items). The reliability and validity of the ptsd-HTQ symptoms have been found to be high. Cronbach alpha, a reliability analysis measure of internal consistency based on the average interitem correlation, was estimated at 0.89 (12). For the ptsd-HTQ symptoms, a validation study conducted among 91 South-east Asian refugee outpatients at the Indochinese Psychiatry Clinic in Boston reported a sensitivity of 78% and a specificity of 65%, in terms of reliability, 1-week test-retest reliability was reported as 0.92 and interrater reliability among Bosnian refugees living in Croatia was estimated as 0.98. The author of the current report was granted permission to use the instrument.

Coping style; manageability. The concept Sense of Coherence (SOC), measuring coping style, used frequently throughout the world and thought to be appropriate to any population, was introduced by Antonovsky (13, 14). A review of studies in different countries using either the long (SOC-29) or the short (SOC-12) version found this instrument to be both valid and reliable. In Sweden, the first author and colleagues have used it in several studies of immigrant and refugee groups from several countries (for a review, see 6).

The short version of the SOC-12 operationalizes the construct in a 12-item, semantic differential questionnaire, and its design is guided by Guttman's facet theory, with a seven-point semantic differential agreement/disagreement scale with two anchoring phases (15). It covers the three components assumed to be of importance for coping: comprehensibility, manageability and meaningfulness. All three dimensions are important for the prevention of ill health. Besides the description of a person's coping ability, the instrument also includes certain existential aspects of a person's life. SOC has been broadened from an earlier concept of connoting quality of life to include one's view of life. The scale is usable both for interview and for self-completion. Possible scores on SOC-12 range from 12 to 84; the higher the score, the stronger the sense of coherence. The median is used as the cut-off for low and high manageability, respectively. The short version, SOC-12, showed, however, limitations in the baseline study. As Cronbach alpha was reliable (at baseline, with a total of 0.59, and for the subscales; meaningfulness 0.08, manageability 0.51 and comprehensibility 0.02) with regard to only one of the three subscales, i.e. manageability, this subscale is analysed in the study. The strong ego-centred items in SOC-12 seemed to be inappropriate for the participants in this study.

Statistical analyses

The Statistical Package for Social Science (SPSS) 10.0 for Windows was used. A variety of statistical tests was used in the analysis of the data. The quantitative items are described by mean ± standard deviation. The differences between means were tested with the non-parametric Mann–Whitney test. The correlations between variables were tested with the Spearman correlation (non-parametric). A probability level of 0.05 was

adopted *a priori* as the minimum level to be considered statistically significant for differences among groups. Internal consistency (Cronbach alpha) was estimated with coefficient alpha.

Results

Sample demographics among respondents

The instruments were administered to 131 mass displaced Kosovars (70 women and 61 men) in the follow-up study, 3 months after the baseline study. The questionnaires were completed by 98 (48 male and 50 female) of the 131 participants, representing a response rate of 75%. The average age of the responders was 39 years (SD = 13.57), average schooling was 9.88 years and 78% were married with the rest being single.

Thirty-three of the 131 participants available in the follow-up study after 3 months (25%; 13 men and 20 female) did not complete the questionnaires. There were no significant differences between responders and this dropout regarding demographics (for further details, see the report, 6).

Exposure to trauma, psychiatric symptoms and gender perspective

Of the 98 participants, 51% (50) confirmed that they had experienced torture, the percentage being higher among men compared with women but no significant differences (58.3%, and 44.0%, respectively, $\chi^2 = 2.013$, $P < 0.156$). The mass displaced adults exposed to torture, in comparison with those who were not exposed to torture, showed higher means on the different self-rated symptoms but there were only significant differences between the two groups on coping style, i.e. manageability. The participants with torture experience, in comparison with those who did not have that experience, showed significantly lower mean scores on manageability (mean = 14.9, SD = 6.78, mean = 18.4, SD = 5.88, respectively, $P < 0.006$).

Table 1 shows that there are significantly higher means on all self-rated symptoms and lower means on coping style, i.e. manageability, among participants with ptsd-HTQ symptoms compared with participants who do not have ptsd-HTQ symptoms. The correlations between the self-rated symptoms were high (for details, see 6). Women have a significantly higher mean on ptsd-HTQ ($P < 0.015$), Depression-Hopkins ($P < 0.0003$) and Anxiety-Hopkins ($P < 0.001$), but not on aggression. However, they have a lower mean on Manageability-SOC ($P < 0.020$) (Table 2).

Table 1. Self-rated symptoms amongst mass displaced Kosovars. Comparison by PTSD symptoms, ptsd-HTQ

Self-rated scales	Ptsd-HTQ, $n = 45$ mean (SD)	Not ptsd-HTQ, $n = 53$ mean (SD)	Mann–Whitney test
Depression, Hopkins	40.67 (7.49)	28.03 (8.52)	0.0001
Anxiety, Hopkins	31.87 (5.42)	19.13 (6.45)	0.0001
Manageability-SOC, Coping	13.53 (5.53)	19.83 (6.50)	0.0001
Total Aggression, AQ-RSV	69.42 (15.92)	57.73 (11.14)	0.001
Physical Aggression, AQ-RSV	19.60 (5.33)	16.79 (4.56)	0.007
Verbal Aggression, AQ-RSV	12.20 (3.91)	10.53 (3.35)	0.046
Anger, AQ-RSV	17.20 (4.48)	14.77 (4.07)	0.005
Hostility, AQ-RSV	15.41 (5.18)	15.73 (4.97)	0.001

Table 2. Means and standard deviation on self-rated symptoms amongst mass displaced adults from a gender perspective

Self-rated scales	Men, $N = 48$ mean (SD)	Women, $N = 50$ mean (SD)	Mann–Whitney test
ptsd-HTQ	30.04 (5.62)	41.18 (13.35)	0.015
Depression, Hopkins	31.29 (10.24)	37.12 (8.93)	0.0013
Anxiety, Hopkins	22.16 (8.35)	27.71 (6.29)	0.001
Manageability-SOC	18.16 (5.87)	15.14 (5.08)	0.028
Total Aggression, AQ-RSV	60.77 (16.37)	64.37 (15.19)	0.124
Physical Aggression, AQ-RSV	17.33 (5.32)	18.33 (4.94)	0.455
Verbal Aggression, AQ-RSV	11.38 (3.52)	11.48 (2.88)	0.575
Anger, AQ-RSV	15.27 (4.62)	16.43 (4.18)	0.142
Hostility, AQ-RSV	16.58 (5.50)	18.17 (5.17)	0.129

Means and standard deviation for self-rated symptoms amongst mass displaced adults from a coping perspective are shown in Table 3. Those participants who have low coping strategies on manageability have a significantly higher mean on the following symptoms: ptsd-HTQ, Depression-Hopkins, Anxiety-Hopkins, Total Aggression-AQ-RSV, Anger-AQ-RSV and Hostility-AQ-RSV.

Reliability analysis

The internal consistency of the instruments, total and subscales, was evaluated by the α-coefficient (Cronbach's alpha) and was high (for detailed figures, see 6).

Discussion

Validity and reliability of instruments

The self-rated instruments for measurement of depression, anxiety, ptsd-HTQ symptoms, aggression and coping style, i.e. manageability, confirm earlier transcultural comparisons regarding good

Table 3. Means and standard deviation on self-related symptoms amongst mass displaced adults from a coping perspective

Self rated scales	High manageability (< mean and ≥ 56 mean (SD)	Low manageability (< mean and ≥ 42 mean (SD)	Main Whitney test
ptsd-HTQ	36.46 (10.24)	41.60 (9.69)	0.010
Depression, Hopkins	31.95 (10.05)	37.48 (9.03)	0.008
Anxiety, Hopkins	22.32 (8.66)	28.52 (7.58)	0.0001
Total Aggression, AQ-RSV	59.92 (18.84)	68.27 (15.53)	0.029
Physical Aggression, AQ-RSV	17.96 (5.02)	18.40 (5.29)	0.625
Verbal Aggression, AQ-RSV	10.98 (3.62)	11.66 (3.75)	0.17
Anger, AQ-RSV	14.82 (4.27)	17.28 (4.29)	0.006
Hostility, AQ-RSV	16.30 (5.35)	18.66 (5.13)	0.013

internal consistency (Cronbach alpha). The strong ego-centred items in SOC-12 seemed to be inappropriate for the participants. There is a need for an instrument, used with a qualitative approach, that is more group-oriented and sensitive to Muslim cultures in perceiving refugee traumatic stress.

High self-rated psychiatric symptoms in mass displaced Kosovars

First, the study confirms that anger and hostility are important consequences of torture. To date, most studies of refugee mental health have not focused on aggression, which seems to be of importance in understanding psychological consequences of torture. The baseline study (6) showed that over half of the participants had experience of torture, a high figure compared with the literature showing 15%–30%. Their 10 years of a parallel system, due to violence in their society, such as transgenerational transmission of frustrations, seems to develop distress and aggressive feelings. As a consequence, their stress level is assumed to be high over a long period, i.e. chronic, and their symptoms must therefore be interpreted in that context. Detection of war trauma-related symptoms, which may thus lead to psychiatric symptoms and anger and hostility, should therefore be incorporated in future studies.

The second finding comes from the study's exploration of the association of poor coping strategies, manageability with torture, psychiatric symptoms (i.e. depression, anxiety and ptsd-HTQ symptoms) and total aggression, anger and hostility. The main findings are that experience of torture is associated with poor coping; that depression, anxiety and aggression are associated with PTSD symptoms; and that all psychiatric symptoms and poor coping style, manageability (but not aggression) are associated with being female. These findings support earlier studies in the literature that females constitute a risk group for distress (3).

Importance of gender difference in assessment and follow-up

Women have a significantly higher mean on ptsd-HTQ ($P < 0.015$), Depression-Hopkins ($P < 0.003$) and Anxiety-Hopkins ($P < 0.001$), but a lower mean on coping style, Manageability-SOC ($P < 0.02$). Women are therefore identified as a risk group. In the baseline study, it was shown that their circumstances of not having close relatives with them may increase their psychological distress (6). Furthermore, they may find themselves cast in new roles as heads of single parent families or as widows. War-related stress, environmental factors, persistent grief, mourning, loneliness and isolation tend to predispose women living in war situations to sustained stress that leads to depression (for a review, see 6). Further research is necessary over time among those who apply for asylum and those who repatriate, in order to understand the association between individual differences in psychiatric symptoms and aggression, which may be a result of complex interactions between the person (i.e. gender, coping), events (i.e. torture experience and ongoing trauma) and environmental factors (e.g. social support, reception programme, repatriation).

Limitations and strengths

Apart from the small sample the present study is limited by the dropout rate during the follow-up and the fact that the participants were in a mass displaced phase with ongoing trauma throughout the study. Those who repatriated during the ongoing study were out of control in this study due to the official 11 month stay in Sweden. The dropouts in the present study, 25%, did not differ significantly from the participants with regard to socio-demographic factors. Furthermore, even though the questionnaires used were carefully translated, back-translated and are based on constructs of mental health symptoms, they may not reflect with total accuracy traumatic stress symptoms in the Kosovo Albanian culture. However, a

standardization of the self-rated instruments is lacking due to the limited time of the mass displaced persons' stay in Sweden.

Also, the study sample consisted of volunteers from mass displaced adults and may not have been representative of the population of refugees from Kosovo province living in Sweden. However, from an ethical point of view, as to whether it is appropriate to ask mass displaced persons about torture experience, the questions were validated to the respondents, and they did not perceive them as being difficult to answer, intrusive or insulting. They also found the questions to be sensitive to their stressful situation (for detailed information, see 6). It seems that in telling the trauma story, a psychosocial strategy is relevant and further research is necessary to understand the coping mechanisms behind such a strategy.

The study's strength is its longitudinal and prospective design. Nevertheless, most of these studies have been limited by their cross-sectional design. The assistants and interpreters at the Swedish Migration Board were a valuable resource in performing the study and were supported by regular supervision. Ninety-three per cent of the participants answered at baseline (6) that they were positive to participating in a follow-up after repatriation if practically possible. Step 2, already confirmed by the Swedish Migration Board, is to perform another follow-up study among those repatriated to the Kosovo province and those who have applied for asylum in Sweden. Challenges for future research include examining the ramifications of receiving a group of mass displaced for a short period of time (i.e. 11 months), and associations among psychiatric symptoms, aggression, emigration status, gender and mortality over time, with the development of sustainable co-operation between local resources and reception facilities.

In conclusion, depression, anxiety, PTSD symptoms and aggression are universal phenomena but do not have similar meanings in different social, cultural and political contexts. Aggression, for instance, may not be relevant to the mental health of one person, whereas for another it is a signal indicating the need of professional health care, and for a third person it may stand for collective memories of oppression.

The lessons learnt from the present study show the importance of early assessment by using screening instruments in a gender-perspective for detecting torture related symptoms and coping strategies, i.e. manageability, among newly arrived mass displaced adults with ongoing trauma. However, mass displaced persons' own perceptions of their needs within the context of general health and social care must be of concern. Leaving the individual better mentally prepared for repatriation can be regarded as an investment.

Acknowledgements

We would like to extend our warmest thanks to all who have contributed to make this work possible. In particular we would like to express our sincere gratitude to: the Swedish Board of Immigration (from 1 July 2000 a new name: Swedish Migration Board) who supported the study by an EU grant entitled 'Swedish Project – Temporary Protection for Persons During the Crisis in Kosovo and While Waiting for Possible Return'. Project Number: JHA-1999/REF/110; the mass displaced refugees from Kosovo who generously gave their time and shared their experiences and thoughts; Mr Anders Westerberg (in charge of the Southern Region, Swedish Migration Board) who inspired and strongly supported this study at the proposal stage; Mrs Lena Häll Eriksson, General Director, Mrs Ewa Lidström and Mr Jörgen Isaksson, at the head office, the contact persons (Ms. Pia Fast and Ms. Gudrun Zetterberg, Northern Region, Mrs Eva Sidenvall, Central Region, Ms. Ulla Winberg, Western Region, and Ms. Elisabeth Östling, Southern Region) and assistants and interpreters at the Swedish Migration Board, for their collaboration and work which contributed to making this study possible; the interpreters (Mr Ullmar Quick and Mr Cazim Uscini) for their meticulous translation work; Dr Richard Mollica, MD at the Harvard Programme in Refugee Trauma, Harvard School of Public Health for his permission to use the Harvard Trauma Questionnaire and his colleague, research co-ordinator Miriam Chernoff, PhD for reading and giving constructive comments on the manuscript; Steve Wicks, for your great help in transforming the text into readable English.

References

1. Mollica RF. Special problems. In: Gelder MG, López Ibor JJ, Andreasson N, eds. New Oxford textbook of psychiatry, 2nd vol. Oxford: Oxford University Press, 2000;1595–1601.
2. Watters C. Emerging paradigms in the mental health care of refugees. Social Sci Med 2001;52:1709–1718.
3. Silove D. Trauma and forced relocation. Current Opinion Psychiatry 2000;13:231–236.
4. Marks DF, Murray M, Evans B, Willig C. Health psychology. Theory, research and practice. London: Sage Publications, 2000.
5. Lopes Cardozo B, Vergara A, Agani F, Gotway CA. Mental health, social functioning and attitudes of Kosovar Albanians following the war in Kosovo. J Am Med Assoc 2000;5:569–577.
6. Ekblad S. A survey of somatic, psychological and social needs of mass displaced refugees from the Kosovo Province while in Sweden. Stress Research Reports nr 293. Stockholm: National Institute of Psychosocial Factors and Health, Division of Psychosocial Factors and Health. Department of Public Health Sciences. Karolinska Institutet, 2000.
7. Brislin R, Lower W, Thorndike R. Cross-cultural research methods. New York: John Wiley, 1973.
8. Ekblad S, Eriksson N-G, Kleberg E-L et al. Ett hälsoblad som screening instrument för nyanlända flyktingar. Del 1–3 (Rapport, Handbok, Frågeformulär Hälsobladet).

Stressforskningsrapport nr 273. Stockholm: National Institute of Psychosocial Factors and Health, Division of Psychosocial Factors and Health. Department of Public Health Sciences. Karolinska Institutet, 1997.

9. Mollica RF, McInnes K, Sarajlic N, Lavelle J, Sarajlic I, Massagli MP. Disability associated with psychiatric co-morbidity and health status in Bosnian refugees living in Croatia. J Am Med Assoc 1999;282:433–439.
10. Eriksson S. Diagnostik och behandling av patienter med invandrarbakgrund. En Enkätundersökning På En Psykiatrisk Öppenvårdsmottagning. Stressforskningsrapport nr 262. Stockholm: National Institute of Psychosocial Factors and Health, Division of Psychosocial Factors and Health. Department of Public Health Sciences. Karolinska Institutet, 1996.
11. Procidiano H, Ahrens H. Aggression in the general Swedish population, measured with a new self rating inventory. The Aggression Questionnaire – revised Swedish version (AQ-RSV). Nordic J Psychiatry 2001;55:17–23.
12. Mollica RF, Caspi Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Indochinese refugees. J Nervous Mental Dis 1992;180:111–116.
13. Antonovsky A. The structure and properties of the Sense of Coherence scale. Social Sci Med 1993;36:725–733.
14. Antonovsky A. Complexity, conflict, chaos, coherence, coercion and civility. Social Sci Med 1993;37:969–974.
15. Antonovsky A. The mysteries of health. San Francisco: Jossey Bass Publishers, 1991.

The Relationship Between Somatic and PTSD Symptoms Among Bhutanese Refugee Torture Survivors: Examination of Comorbidity With Anxiety and Depression

Mark Van Ommeren,[1,2,5] Bhogendra Sharma,[1] Gyanendra K. Sharma,[1] Ivan Komproe,[2,3] Etzel Cardeña,[4] and Joop T. V. M. de Jong[2,3]

Previous research has indicated a relationship between posttraumatic stress disorder (PTSD) and somatic complaints. We examined whether this relationship is a result of shared comorbidity with anxiety and depression. Local doctors interviewed a random, community sample of 526 tortured and 526 nontortured Bhutanese refugees living in U.N. refugee camps in Nepal. The interview covered demographics, torture, somatic complaints, and PTSD, depression, and anxiety measures. Number of PTSD symptoms, independant of depression and anxiety, predicted both number of reported somatic complaints and number of organ systems involving such complaints. Physicians need to screen for PTSD when survivors of extreme stressors present nonspecific somatic complaints.

KEY WORDS: PTSD; somatic complaints; refugees; comorbidity; torture.

Help-seeking survivors of physical torture frequently report somatic distress (Goldfeld, Mollica, Pesavento, & Faraone, 1988; Sharma & Van Ommeren, 1998). Such distress may involve long-term organic damage (Nice, Garland, Hilton, Baggett, & Mitchell, 1996). Physical and laboratory tests may, however, determine no apparent organic cause for survivors' somatic complaints, as has been our clinical observation in Nepal (Sharma & Van Ommeren, 1998; Van Ommeren, Sharma, Prasain, & Poudyal, in press). Unexplained complaints related to diverse organ systems may indicate psychiatric morbidity (Escobar, Burnam, Karno, Forsythe, & Golding, 1987).

[1]Center for Victims of Torture Nepal in Kathmandu, Kathmandu, Nepal.
[2]Transcultural Psychosocial Organization, World Health Organization Collaborating Centre for Refugees and Ethnic Minorities in Amsterdam, Amsterdam, The Netherlands.
[3]Faculty of Medicine, Vrije Universiteit in Amsterdam, Amsterdam, The Netherlands.
[4]Department of Psychology and Anthropology, University of Texas, Pan American, Texas.
[5]To whom correspondence should be addressed at Keizersgracht 329, 1016 EE Amsterdam, The Netherlands; e-mail: mark_van_ommeren@hotmail.com.

Torture has been associated with a wide range of psychosocial sequelae (Somnier, Vesti, Kastrup, & Genefke, 1992), including symptoms of posttraumatic stress disorder (PTSD; Basoglu et al., 1994; Mollica et al., 1993; Shrestha et al., 1998). A variety of studies have shown that those suffering from PTSD tend to be more likely to report nonspecific somatic complaints than do those without PTSD (Baker, Mendenhall, Simbart, Magan, & Steinberg, 1997; McFarlane, Atchison, Rafalowicz, & Papay, 1994; Schnurr & Jankowski, 1999), even when the groups do not differ on physical and laboratory tests (Litz, Keane, Fisher, Marx, & Monaco, 1992; Shalev, Bleich, & Ursano, 1990). Yet, as PTSD has high comorbidity with anxiety and depression (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), shared comorbidity may explain somatic distress among those with PTSD, because anxiety and depression are associated with physical symptom reporting (Bridges & Goldberg, 1985; Kirmayer, Robbins, Dworkind, & Yaffe, 1993). Previously, Zatzick et al. (1997) and Bramsen (1995) reported an association between health status and PTSD, after adjusting for psychiatric comorbidity, among, respectively, male Vietnam

veterans and Dutch World War II survivors. It is not clear whether this adjusted relation is also found among torture survivors outside the West.

We tested whether there is a relationship between somatic and PTSD symptoms, independent of comorbid depression and anxiety, in a large, random, community sample of tortured and nontortured Nepali-speaking Bhutanese refugees living in Nepal. Considering that clinical observation and our client's record system show that in Nepal help-seeking torture survivors mostly present somatic complaints (Van Ommeren et al., 2002), it is especially relevant to apply our research question to this population.

Method

Participants

The details of the data collection methods have been described in greater detail in a paper on the impact of physical torture on adult Bhutanese refugees (Shrestha et al., 1998). The Bhutanese refugees sought refuge in Nepal after persecution by Bhutan's Drukpa security forces. The refugees are descendants of Nepali settlers. They speak Nepali and follow combinations of Hindu, Buddhist, and animistic traditions.

The population from which we sampled consisted of 2,331 physically tortured, Nepali-speaking Bhutanese refugees living in the U.N. refugee camps in southeastern Nepal. A sample size of 600 was determined to provide sufficient statistical power for analyses. As 15 cases (2%) could not be traced, we sampled an additional 20 cases. Out of 620 approached cases, 601 (97%) were available for interviewing. A control group of nontortured refugees, matched on age and sex, was also interviewed. Ten-year difference was accepted as an age match, and matching on sex was exact. After excluding those younger than 19 and incorrect matches, 526 matched pairs (88%) remained.

The matched tortured and nontortured refugees were similar on most demographic variables. The matched samples consisted of 404 men and 122 women. The average age of the torture survivors was 41.7 ($SD = 12.5$); the average age of nontortured refugees was 41.5 ($SD = 12.5$). The vast majority of tortured and nontortured refugees reported being married (see Table 1). Among tortured

Table 1. Demography of 526 Tortured and 526 Nontortured Bhutanese Refugees

Variable	Tortured ($n = 526$)		Nontortured ($n = 526$)		
	N	%	*N*	%	χ^2
Marital status					
Single	25	5	15	3	2.6
Married	478	91	468	89	1.0
Widow(er)	20	4	31	6	2.5
Divorced/separated	3	1	12	2	5.5
Religion					
Hindu	475	90	447	85	6.9*
Buddhist	45	9	73	14	7.5*
Other	6	1	6	1	0
Education					
Illiterate	245	47	288	55	7.0*
Literate through nonformal education	150	29	115	22	6.2
Primary (1–5)	88	17	75	14	1.2
Middle (6–8)	20	4	33	6	3.4
Higher (9–12)	20	4	13	2	1.5
College	3	1	2	0	[a]
Occupation in Bhutan					
Agriculture	388	74	408	78	2.1
Service	39	7	41	8	0.1
Other	99	19	77	15	3.3
Member of a political or human rights organization in Bhutan	73	14	41	8	10.1**
History of physical illness	64	12	96	18	7.5*
History of mental illness	14	3	24	5	2.7
Epilepsy	3	1	13	3	6.3
Physical illness in the family	40	8	36	7	0.2
Mental illness in the family	15	3	21	4	1.0
Epilepsy	8	2	11	2	0.5

[a] The two-tailed Fisher's Exact Test was applied when the expected frequencies were less than 5.0 for two or more cells of a 2 × 2 table.
*$p < .01$. **$p < .005$.

refugees, 90% identified themselves as Hindu, 9% as Buddhist, and 1% as *other*. Significantly more nontortured refugees identified themselves as Buddhist (14%). Approximately half the tortured refugees reported being illiterate, 3 out of 10 reported obtaining literacy through nonformal education, 1 out of 6 reported having attended primary school, and 1 out of 11 reported having more than 5 years of formal education. Among nontortured refugees, the percentages were similar with the exception that more nontortured refugees reported being illiterate. Nontortured refugees were more likely to have a history of significant physical illness compared to tortured refugees. More tortured refugees had been members of a political or human rights organization in Bhutan. Both tortured and nontortured refugees had been in the camps in Nepal for 3.4 years ($SD = 0.6$).

Instrumentation

The interview schedule included questions covering (in this order) demographics, family and personal history of mental and physical health, and anxiety and depression symptoms as assessed by the Hopkins Symptom Checklist (HSCL-25; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), a checklist of 52 types of physical torture believed to occur in Bhutan, and a list of 17 questions covering a Nepali translation of the *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* (*DSM-III-R*; American Psychiatric Association [APA], 1987) criteria for PTSD. We used the World Medical Association (1987) definition of torture.

The interview schedule also contained a checklist of 25 somatic complaints, covering nervous, musculoskeletal, gastrointestinal, genitourinary, cardiovascular, and respiratory system symptoms, and weakness. Cronbach's alpha internal consistency coefficient in this sample was .88 for the corrected HSCL-25 anxiety score and .89 for the HSCL-25 depression score.

Procedure

Data were collected in 1995. Interviews were conducted by Nepali medical doctors, who had received 1-day training in differential diagnosis of PTSD. Participants were offered a physical examination in return for participating. Participants were asked about traumatic events before or during their flight, such as torture, sexual assault, murder of relatives, witnessing atrocities, physical destruction of one's community, threats, and lack of food and shelter. The doctors did not record which events were identified by participants as reference events for PTSD assessment. The doctors performed brief physical examinations, without laboratory tests or roentgenograms, to complete the checklist of physical complaints. The doctors were blind to the research hypothesis tested in this report. Because of both illiteracy and mistrust, verbal rather then written informed consent was obtained.

Data Analysis

Hierarchical regression analyses were performed to identify predictors of (a) number of somatic complaints and (b) number of organ systems involving somatic complaints. We added relevant demographics (age, sex, education, and religion) in Step 1, torture status in Step 2, anxiety and depressive symptoms in Step 3, and PTSD symptoms in the last step. Because the diagnosis of PTSD is a very specific outcome, we included number of PTSD symptoms instead of presence or absence of diagnosis.

To avoid endogeneity, items covering weakness, headaches, and palpitations were removed from the HSCL-25 anxiety score. The three items are part of the list of 25 somatic complaints and, consequently, have no explanatory power in the regression analyses. We will call the anxiety score that results after removing these items the corrected HSCL-25 anxiety score.

Data were complete on relevant variables. An alpha level of .05 was used for all analyses except for univariate analyses comparing demographics of the tortured and nontortured participants. For the latter analyses, the alpha level was set at .01 to reduce chance significance caused by multiple tests. All analyses were performed with commercially available software (SPSS Inc., 1995).

Results

The most frequently reported physical torture techniques were severe beatings (97%), being tied up with ropes or chains (52%), forced labor (26%), hair torture (17%), prolonged standing (15%), cold torture (14%), *chepuwa* (14%), and ear torture (11%). *Chepuwa* involves the tight clamping of thighs or legs with bamboo for an extended period of time.

PTSD symptoms were more frequently reported in the tortured group than in the nontortured group, 3.4 ($SD = 3.9$) versus 1.4 ($SD = 2.5$), $t(1050) = 10.02$, $p < .001$. Out of 526 tortured refugees, 199 (38%) reported no *DSM-III-R* PTSD symptoms, 155 (29%) reported 1–4 PTSD symptoms, and 172 (33%) reported 5 or more PTSD symptoms (maximum = 16). Out of

Table 2. Correlations Among Depression and Anxiety Scores, Number of Somatic Complaints, Number of Organ Systems Involving Somatic Complaints, and Number of Posttraumatic Stress Disorder (PTSD) Symptoms

Variable	Tortured (yes/no)	Depression	Anxiety[a]	PTSD symptoms	Somatic complaints
Depression	.11				
Anxiety[a]	.14	.78			
PTSD symptoms	.30	.74	.62		
Somatic complaints	.20	.32	.29	.33	
Organ systems involving organic complaints	.28	.34	.32	.40	.87

Note. All correlations are significant at $p < .001$.
[a]Corrected score. Items covering weakness, headache, and palpitations were excluded from the anxiety score to avoid endogeneity with somatic complaints.

526 nontortured refugees, 335 (64%) reported no PTSD symptoms, 131 (25%) reported 1–4 PTSD symptoms, and 60 (11%) reported 5 or more PTSD symptoms (maximum = 15).

Also, somatic complaints were more frequently reported in the tortured group than in the nontortured group, 2.5 ($SD = 2.1$) versus 1.8 ($SD = 1.5$), $t(1050) = 6.63$, $p < .001$. Eighty-two survivors (16%) reported no somatic complaints, 375 survivors (71%) reported 1–4 somatic complaints, and 69 survivors (13%) reported 5 or more somatic complaints (maximum = 16). Similarly, the tortured group, compared to the nontortured group, had a higher number of organ systems with somatic complaints, 2.2 ($SD = 1.5$) versus 1.5 ($SD = 1.1$), $t(1050) = 9.61$, $p < .001$. Four hundred and four survivors (76%) had complaints in 1–4 organ systems, and 41 survivors (8%) had complaints in 5 or more organ systems. Torture status, number of somatic complaints, number of organ systems involving somatic complaints, number of PTSD symptoms, the corrected HSCL-25 anxiety score, and the HSCL-25 depression score all correlated significantly (see Table 2).

Hierarchical regression analyses identified demographics (female sex, higher age), torture, and PTSD symptoms as predictors of both number of somatic complaints and number of organ systems involved (see Table 3). Depression predicted number of somatic complaints but did not predict number of organ systems involved. Anxiety predicted neither. Torture continued to be significant when PTSD and comorbid depression and anxiety were added. PTSD continued to predict somatic outcome, when adjusting for comorbid depression and anxiety. PTSD, torture, and their interaction were all significant, suggesting that a history of torture strengthened the effect of PTSD symptoms on somatic outcome. After the final step, with all independent variables in the equation, $R^2 = .17$, $F(9, 1042) = 24.5$, $p < .001$, for the regression with number of somatic complaints as the outcome and, $R^2 = .24$, $F(9, 1042) = 36.8$, $p < .001$, for the regression with number of organ systems as the outcome.

Discussion

This study among Bhutanese refugees shows a specific association between PTSD symptoms and health status independent of anxiety and depression, and, thereby, replicates earlier findings by Zatzick et al. (1997) and Bramsen (1995) in the West. In addition, age, exposure to torture, and depression also independently predicted health status. The latter findings are consistent with previous research showing an association between exposure to trauma and somatic complaints (e.g., Center for Disease Control, 1988; Labbate, Cardeña, Dimitreva, Roy, & Engel, 1998) and between depression and somatic complaints (e.g., Bridges & Goldberg, 1985).

Several theories explain the relation between somatic and PTSD symptoms. First, research has shown an association between psychological stress and harmful physiological consequences (Chrousos & Gold, 1992). As traumatic stress is an extreme form of stress, harmful physiological consequences leading to somatic complaints can be expected (Friedman & Schnurr, 1995). Moreover, traumatization is associated with neurobiological changes, increased physiological arousal, and increased adverse health practices—all of which can have somatic sequelae (Friedman & Schnurr, 1995; Kirmayer, 1996; McFarlane et al., 1994; Shalev et al., 1990). In addition, our clinical experience in Nepal suggests a cognitive explanation: Torture often involves the implicit message that the body is being permanently damaged, which may result not only in a PTSD reaction but also in a heightened focus on somatic sensations interpreted as indicating damaged functioning.

Similar to much of the previous research reported on PTSD and somatic complaints (e.g., Baker et al., 1997; McFarlane et al., 1994), our study is limited because interviewers did not distinguish between medically explained

Table 3. Hierarchical Regression Analyses on Two Measures of Somatic Outcome

	Regression 1 (No. of somatic complaints)				Regression 2 (No. of organ systems involved)			
	B	*SE B*	*β*	R^2	*B*	*SE B*	*β*	R^2
Step 1[a]				.025				.025
Sex (male)	−.27	.15	−.06		−.17	.11	−.05	
Age	.02	.00	.10*		.01	.00	.12*	
No. of years of schooling	−.08	.06	−.05		−.02	.04	−.01	
Religion (Buddhist/no Buddhist)	−.42	.18	−.07*		−.37	.13	−.08*	
Step 2[b]				.064				.103
Sex (male)	.26	.14	.06		.16	.10	.05	
Age	.01	.00	.10*		.01	.00	.12*	
No. of years of schooling	−.10	.06	−.06		−.04	.04	−.03	
Religion (Buddhist/no Buddhist)	.32	.18	.05		.27	.13	.06*	
Tortured (yes/no)	.75	.11	.20*		.78	.08	.28*	
Step 3[c]				.154				.221
Sex (male)	−.29	.14	−.07*		−.19	.10	−.06*	
Age	.02	.00	.13*		.02	.00	.15*	
No. of years of schooling	−.13	.05	−.07*		−.06	.04	−.05	
Religion (Buddhist/no Buddhist)	.26	.17	.04		.21	.12	.05	
Tortured (yes/no)	.40	.11	.11*		.48	.08	.18*	
No. of PTSD symptoms	.18	.02	.32*		.15	.01	.36*	
Step 4[d]				.160				.231
Sex (male)	.31	.14	.07*		.20	.09	.06*	
Age	.02	.00	.13*		.02	.00	.15*	
No. of years of schooling	−.12	.05	−.07*		−.05	.04	−.04	
Religion (Buddhist/no Buddhist)	−.26	.17	−.04		−.22	.12	−.05	
Tortured (yes/no)	.44	.11	.12*		.52	.08	.19*	
No. of PTSD symptoms	.15	.02	.28*		.13	.01	.31*	
Torture × No. of PTSD symptoms[e]	.17	.06	.08*		.16	.04	.11*	
Step 5[f]				.174				.241
Sex (male)	−.27	.13	−.06*		−.18	.09	−.05	
Age	.02	.00	.13*		.02	.00	.15*	
No. of years of schooling	.10	.05	.06		.04	.04	.03	
Religion (Buddhist/no Buddhist)	−.23	.17	−.04		−.20	.12	−.04	
Tortured (yes/no)	.52	.11	.14*		.56	.08	.20*	
No. of PTSD symptoms	.07	.03	.13*		.08	.02	.20*	
Torture × No. of PTSD symptoms[e]	.18	.06	.09*		.16	.04	.11*	
No. of depression symptoms	.05	.02	.15*		.02	.01	.09	
No. of anxiety symptoms[g]	.02	.02	.04		.03	.02	.07	

Note. PTSD indicates *DSM-III-R* posttraumatic stress disorder. F_{change} was significant for each step for both regression analyses.

[a] $R^2 = .025$ for Step 1 of Regression 1; $R^2 = .025$ for Step 1 of Regression 2.

[b] $\Delta R^2 = .039$ for Step 2 of Regression 1; $\Delta R^2 = .078$ for Step 2 of Regression 2.

[c] $\Delta R^2 = .090$ for Step 3 of Regression 1; $\Delta R^2 = .118$ for Step 3 of Regression 2.

[d] $\Delta R^2 = .006$ for Step 4 of Regression 1; $\Delta R^2 = .0098$ for Step 4 of Regression 2.

[e] The interaction between torture and PTSD was calculated by entering the product of the *Z* scores of the variables, torture and number of PTSD symptoms.

[f] $\Delta R^2 = .014$ for Step 5 of Regression 1; $\Delta R^2 = .010$ for Step 5 of Regression 2.

[g] Corrected score. Items covering weakness, headache, and palpitations were excluded from the HSCL-25 anxiety score to avoid endogeneity with somatic complaints.

*$p < .05$.

and unexplained complaints. However, as somatization has been associated with presence of multiple complaints in diverse areas of the body (Escobar et al., 1987), our finding that number of PTSD symptoms predicts number of organ systems involving complaints confirms our clinical impression that many of these complaints are medically unexplained.

Our study is also limited because of the absence of reliability data on the PTSD assessment by the general physicians, who received only 1-day training in PTSD assessment. Given that validity is limited to the extent that measures reliably assess what is being measured, this is a serious limitation and our findings need therefore to be interpreted with caution. PTSD Criterion A assessment would have benefited from inclusion of a systematic assessment of refugee trauma events, such as that incorporated in the Harvard Trauma Questionnaire (Mollica et al., 1991). The fact that torture was self-reported may have

increased the probability of Type II error, causing a bias against finding significant differences between the groups. However, we did find significant differences, indicating the robustness of our findings. The study involves *DSM-III-R* criteria (APA, 1987) because the preparations for this study started before publication of *DSM-IV* (APA, 1994). A major strength of this work is that our sample represents the population of tortured Bhutanese refugees. With very few exceptions (e.g., Mollica et al., 1993), refugee studies have involved selected samples of people who managed to find refuge in the West or nonrandom samples of refugees living in low-income countries. Because of the logistical difficulties of collecting information in low-income countries, population-based information remains sparse.

The present findings do not necessarily generalize to torture survivors from other cultures and societies. Culture influences somatic complaints in various ways, including explanatory models, previous illness experiences, help-seeking behavior, occult organic diseases or nutritional deficiencies, persistent feelings of physical vulnerability, and local idioms of distress (Kirmayer, 1996). Moreover, culture likely influences both the nature and extent of PTSD (Marsella, Friedman, Gerrity, & Scurfield, 1996).

In conclusion, regression analyses identified a strong association between somatic and PTSD symptoms, independent of anxiety and depression, among refugee survivors of physical torture. Our findings support Baker et al.'s conclusion that physicians should screen for PTSD symptoms when treating nonspecific somatic complaints of persons who have been exposed to severe stress (Baker et al., 1997).

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd rev. ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Baker, D. G., Mendenhall, C. L., Simbart, L. A., Magan, I., K., & Steinberg, J. L. (1997). Relationship between posttraumatic stress disorder and self-reported physical symptoms in Persian Gulf War veterans. *Archives of Internal Medicine, 157*, 2076–2078.

Basoglu, M., Paker, M., Paker, O., Ozmen, E., Marks, I., Incesu, C., et al. (1994). Psychological effects of torture: A comparison of tortured with nontortured political activists in Turkey. *American Journal of Psychiatry, 151*, 76–81.

Braeuer, L. (1995). *The long-term psychological adjustment of World War II survivors in The Netherlands*. Delft, The Netherlands: Eburon.

Bridges, K. W., & Goldberg, D. P. (1985). Somatic presentation of DSM-III psychiatric disorders in primary care. *Journal of Psychosomatic Research, 29*, 563–569.

Centers for Disease Control. (1988). Health status of Vietnam Veterans: II. Physical health. *Journal of the American Medical Association, 259*, 2708–2714.

Cleroussos, G. P., & Gold, P. W. (1992). The concept of stress and stress system disorders: Overview of physical and behavioral homeostasis. *Journal of the American Medical Association, 267*, 1244–1252.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioural Science, 19*, 1–15.

Escobar, J. I., Burnam, A., Karno, M., Forsythe, A., & Golding, J. M. (1987). Somatization in the community. *Archives of General Psychiatry, 44*, 713–718.

Friedman, M. J., & Schnurr, P. P. (1995). The relationship between trauma, posttraumatic stress disorder, and physical health. In M. J. Friedman, D. S. Charney, & A. Y. Deutch (Eds.), *Neurobiological and clinical consequences of stress: From normal adaptations to PTSD* (pp. 507–524). Philadelphia: Lippincott-Raven.

Goldfeld, A. E., Mollica, R. F., Pesavento, B. H., & Faraone, S. V. (1988). The physical and psychological sequelae of torture. *Journal of the American Medical Association, 259*, 2725–2729.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*, 1048–1060.

Kirmayer, L. J. (1996). Confusion of the senses: Implications of ethnocultural variations in somatoform and dissociative disorders for PTSD. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 131–163). Washington, DC: American Psychological Association Press.

Kirmayer, L. J., Robbins, J. M., Dworkind, M., & Yaffe, M. (1993). Somatization and the recognition of depression and anxiety in primary care. *American Journal of Psychiatry, 150*, 734–741.

Labbate, L. A., Cardena, E., Dimitreva, J., Roy, M., & Engel, C. C. (1998). Psychiatric syndromes in Persian Gulf War veterans: An association of handling dead bodies with somatoform disorders. *Psychotherapy and Psychosomatics, 67*, 275–279.

Litz, B. T., Keane, T. M., Fisher, L., Marx, B., & Monaco, V. (1992). Physical health complaints in combat related posttraumatic stress disorder. *Journal of Traumatic Stress, 5*, 131–141.

Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (Eds.). (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*. Washington, DC: American Psychological Association Press.

McFarlane, A. C., Atchison, M., Rafalowicz, E., & Papay, P. (1994). Physical symptoms in posttraumatic stress disorder. *Journal of Psychosomatic Research, 38*, 715–726.

Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indo-Chinese refugees. *Journal of Nervous and Mental Disease, 180*, 110–115.

Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., et al. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand–Cambodia border camps. *Journal of the American Medical Association, 270*, 581–586.

Nice, D. S., Garland, C. F., Hilton, S. M., Baggett, J. C., & Mitchell, R. E. (1996). Long-term health outcomes and medical effects of torture among US navy prisoners of war in Vietnam. *JAMA, 276*, 375–381.

Schnurr, P. P., & Jankowski, M. K. (1999). Physical health and posttraumatic stress disorder: Review and synthesis. *Seminars in Clinical Neuropsychiatry, 4*, 295–304.

Shalev, A., Bleich, A., & Ursano, R. J. (1990). Posttraumatic stress disorder: Somatic comorbidity and effort tolerance. *Psychosomatics, 31*, 197–203.

Sharma, B., & Van Ommeren, M. (1998). Preventing torture and rehabilitating survivors in Nepal. *Transcultural Psychiatry, 35*, 85–97.

Shrestha, N. M., Sharma, B., Van Ommeren, M., Regmi, S., Makaju, R., Komproe, I., et al. (1998). Impact of torture on refugees displaced within the developing world: Symptomatology among Bhutanese refugees in Nepal. *Journal of the American Medical Association, 280,* 443–448.

Sommer, F., Vesti, P., Kastrup, M., & Genefke, I. K. (1992). Psychosocial consequences of torture: Current knowledge and evidence. In M. Basoglu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 151–181). Cambridge: Cambridge University Press.

SPSS Inc. (1995). *Statistical package for the social sciences* (Version 6.1.3). Chicago: Author.

Van Ommeren, M., Sharma, B., Prasain, D., & Poudyal, B. (2002). Addressing human rights violations: A public mental health perspective on helping torture survivors in Nepal. In J. T. V. M. de Jong (Ed.), *Trauma and war: Public mental health approach in the sociocultural context* (pp. 259–282). New York: Plenum.

World Medical Association. (1987). The declaration of Tokyo, 1975. *Danish Medical Bulletin, 34,* 203–204.

Zatzick, D. F., Marmar, C. R., Weiss, D. S., Browner, W. B., Metzler, T. J., Golding, J. M., et al. (1997). Posttraumatic stress disorder and functioning and quality of life outcomes in a national representative sample of male Vietnam veterans. *American Journal of Psychiatry, 154,* 1690–1695.

Forensic evaluation of sequels to torture

Thomas Wenzel

Purpose of review

In recent years, sequels to torture as a specific and frequent form of social violence have become a major focus of research and clinical practice. A shift in attention from physical to short and long-term sequels has been followed by a large number of studies that have demonstrated sequels to be highly prevalent in different populations and that the scale of the problem has been underestimated before. The review focuses on forensic aspects of political torture.

Recent findings

Studies published over the last years are characterized by the increasing use of structured criteria and interviews, but also by a growing understanding of torture as a phenomenon that is embedded in other negative life events and culture-dependent reactions that might contribute to the severe suffering of many survivors. This makes forensic evaluation but also rehabilitation a complex challenge. Epidemiological studies underline that torture and persecution-related sequels are partly covered by the post-traumatic stress disorder concept, but a too narrow focus on the combination of this causal link and torture as an isolated act might not do justice to all factors. The lack of integration of psychological with psychophysiological imaging and somatic findings reflects the present focus on epidemiological approaches that are necessary for a culture-sensitive and community-oriented approach to support the victims, but require an additional focus in future forensic research.

Summary

Forensic evaluation of sequels to torture is still a developing field in spite of excellent recent studies. Psychiatrists must be careful to avoid retraumatization and respect the survivor, while following an open approach to the possible complex physical and psychological sequels that cannot be reduced to a simple universal model.

Keywords

post-traumatic stress disorder, torture, forensic psychiatry, refugees

Curr Opin Psychiatry 15:611–615 © 2002 Lippincott Williams & Wilkins

University Hospital for Psychiatry, Vienna, Austria

Correspondence to Dr Thomas Wenzel, University Hospital for Psychiatry, Währinger Gürtel 18-20, A-1090 Vienna, Austria.
Tel: +43 575 626 7971; fax: +43 1 489 32 05; e-mail: drthomaswenzel@xnb.de

Current Opinion in Psychiatry 2002, 15:611–615

Abbreviations

PET	position emission tomography
PTSD	post-traumatic stress disorder

1351-7987

Introduction

Torture has developed to be a key case example for the development of disorders after extreme social violence. As a result of its far spread use in a majority of countries worldwide [1], it could be seen as one of the most important mental health 'hazards'. The intention to frighten, punish or impair the self-esteem and assertiveness of survivors and their social environment, creating long-term psychological sequels, are important aspects that separate torture from other severe stressors. Forensic expertise can be sought in critical areas, but requires special care to be taken.

Definitions

In general, definitions of what is covered by the term depend on the framework of reference, which is usually restricted to the torture committed by government representatives or that used in a political context. The term 'torture' in the broader linguistic sense is also frequently used in other contexts, as in 'civil' social violence, domestic violence and child abuse. The laws of most countries and international agreements such as the United Nations Convention [2] restrict the expressive use of the word to the former definitions, which will also be used in the following article, although sequels might be at least partly similar. In practice, physical torture is usually combined with psychological torture [3]. It might be noted that 'torture is permissible under no circumstances whatsoever' [2,4].

Forensic expertise can be necessary in the case of the documentation of abuses or in recompensation, which is often difficult to attain. It is also frequently used in the case of asylum procedures to establish 'justified fear of persecution' and to evaluate possible impairment during legal procedures [5].

Sequels

Since early pioneering studies and papers on the sequels of concentration camps [6], persistent psychiatric sequels have been demonstrated in a series of studies with survivors of different situations of persecution and torture [3,5,7**,8*]. The introduction of a clearly defined concept – post-traumatic stress disorder (PTSD) – for trauma-related sequels, first in the Diagnostic and Statistical Manual of Mental Disorders III [9], has been an important but also a limiting step in empirical research. In contrast to unspecific symptoms of depression, somaroform and anxiety disorders also observed in most victims [3,7**], some of the PTSD cluster symptoms, especially selective avoidance, intrusive symptoms of

concrete events and trigger-specific psychophysiological reactivity, are directly linked to specific experiences. PTSD is also a trauma-specific disorder, as it is not usually a result of everyday stressors. Other sequels that can be seen as characteristic for social violence but are not part of a specific disorder include paradoxical shame and guilt feelings in victims, resulting from different situational factors and behavioural changes.

Methodological development and limitations in the diagnosis of sequels

Standardized interviews but also questionnaires such as the Harvard Trauma Questionnaire [10], which covers torture-related PTSD and associated symptoms, including shame and guilt feelings or the more general Hopkins Symptom Checklist 25 [11], have become a standard in research and are available in culture-sensitive translations [12].

However, forensic psychiatrists should also be aware of results from qualitative and ethnological research to avoid inadequate generalizations and a too narrow focus, as demonstrated by, among others, Van Ommeren and colleagues [7••,13••]. In several studies, item groups are added or omitted to reflect cultural perceptions of trauma and symptoms of distress [14•]. Suffering that reflects complex and culture-dependent reactions and might also be of major importance for social adaptation and quality of life is not covered by present standard instruments [13••]. Evaluation in this area therefore depends mainly on clinical judgement and experience. Under special circumstances such as forensic evaluation in a cross-cultural setting, advice from experts from a specific culture will be necessary to avoid errors.

Although several earlier efforts have been made to standardize the documentation of physical sequels [15], similar guidelines are still under preparation for psychological sequels.

The need for a precise neurological and neuroradiological assessment in the face of a high prevalence of brain or peripheral nerve trauma, and also the symptom overlap of neurological symptoms with PTSD and affective disorders, has been stressed by several recent reviews [16•,17•], but is rarely taken into account in research. Frequent torture-related events include blunt or penetrating head trauma, asphyxiation, malnutrition and disturbed electrolyte balance. All can lead to neuropsychological impairment, followed by short or long-term sequels, including post-concussional syndrome [16•,17•].

Prevalence of torture and predictors of sequels

Basoglu *et al.* [3], in an earlier pioneering study, described a complex set of factors besides the physical severity of torture such as the presence of a socio-psychological framework of reference. Impact and social support after the event itself appears to influence the prevalence and intensity of the symptoms [3], with different importance for PTSD and anxiety/depression. PTSD diagnostic criteria were met in 33% at some time; 18% suffered from present full PTSD, but partial PTSD was present in a larger group.

Whereas research on asylum seekers [8•,18•] indicated that several factors such as help-seeking [19], sex [7••], and post-trauma factors including exile [20] might influence reported prevalence rates, increasing attention has been paid to larger samples of risk groups either still in the country of origin or in the post-war areas [21–23•].

Van Ommeren *et al.* [7••] and Shrestha *et al.* [24] have published results from a major study with Bhutanese refugees in Nepal. Shrestha *et al.* [24] found torture to be the most important predictor of anxiety, depression and PTSD in 526 tortured individuals, using an age and sex-matched group of non-tortured Bhutanese, as did Silove *et al.* [8•] in a sample of 107 Tamil refugees living in Australia. Shrestha *et al.* [24] also noted lower rates of sequels in religious (Buddhist) subgroups of the sample.

Similar to other studies [5], Shrestha *et al.* [24] found a high ICD-10 PTSD life-time prevalence rates of 73.1%, affective disorder in 35.6%, generalized anxiety disorder in 20.6%, and specific to this study, persistent pain disorder in 56.2% and dissociative disorders in 19.4% with significantly lower rates in the non-tortured refugee group. The finding illustrates, that at some point in the longitudinal development, probability is high that a survivor will develop some sort of anxiety disorder, mainly PTSD, but also other less specific disorders and that the use of a broader diagnostic approach uncovers disorders that might reflect more complex reactions and also the earlier concepts of post-traumatic conversion.

De Jong *et al.* [25••] demonstrated torture to be a predictor of psychiatric symptoms in three out of four samples taken from different post-conflict regions; other predictive factors differed from region to region.

Special issues in forensic psychiatric assessment

Memory disorders and impaired attention are part of PTSD, but also present in affective disorders, anxiety, brain injury, electrolyte imbalance, and protective coping strategies such as dissociation, which have been demonstrated to be frequent in survivors and must be expected in an evaluation. The often-intentional construction of torture strategies that are designed to confuse, give wrong information, or create disorientation in time and space must also be seen as a special handicap in getting

an unequivocal or complete report on events. Efforts to discredit the survivor and hide atrocities can contribute to difficulties of later assessment [26]. Impaired memory recall can therefore be a major obstacle to history taking and legal procedures, but is also an indicator of sequels in evaluation. Collateral-reliable data, such as service records in Vietnam veterans, might be difficult to obtain in survivors of torture. Recent studies indicated that neurophysiological assessment of the power spectral electrocardiogram [27] or other psychophysiological parameters [28•] might be helpful in PTSD assessment, but no studies have so far been published with regard to torture. Assessment would in this case evaluate unspecific base-line and more specific script-related activation. Advanced techniques in neuroimaging such as adapted position emission tomography (PET) applications could demonstrate PTSD-related changes [29•]. A polydiagnostic approach might still be the best approach, but also leaves issues unresolved, and could lead to undue stress or re-traumatization in the patient, which is a key issue, as many environmental or situational factors such as instruments, questioning, or even closed doors can trigger PTSD symptoms. Doctors are also frequently involved in torture or are seen as state agents, and are therefore not to be trusted by many patients [30].

In spite of the well documented prevalence of torture and its sequels, victims of violence, not only of torture, frequently face denial and disbelief [26]. In our opinion, the credibility issue should be carefully considered in all cases, following the ethical principle of '*primum non nocere*'. The many possible reasons for the impairment of memory or concentration underline the need for a comprehensive evaluation using data on the region and social background, physical findings, and all data that do not put an inordinate amount of stress on the survivor. Simulated or aggravated profiles are only to be expected under special circumstances, as the stigma attached to a psychiatric diagnosis and the lack of exposure to information about sequels in most countries makes it an improbable option. Montgomery *et al.* [31] demonstrated that reports of survivors can be highly reliable in key areas of reported torture. Other studies listed above indicate under-reporting in many survivors [7••,19].

In transcultural settings, care must also be taken in the use of translators. Translators can distort information, be seen as or act as representatives of persecuting governments, and can also be victims of vicarious traumatization. The fear of disclosing shameful experiences, especially rape and other forms of sexual torture can lead to incomplete reporting, especially in cultures in which known victims of rape are stigmatized or persecuted even by family members. In sex-related or sexual torture, the forensic psychiatrist might have to be of the same sex to foster trust.

Children as victims of torture

Even children are tortured, as shown by Petersen and Wandall [32], but are also even more frequently witnesses, and therefore suffer indirect traumatization, as Montgomery and Foldspang [33••] demonstrated in a study with 311 refugee children from the Middle East. Although torture sequels in children can be different from those in adults, and trauma-related symptoms take different forms compared with adults in childhood trauma, few other research publications have so far dealt with the issue of evaluation. Forensic evaluation and treatment programmes should probably be more aware of the needs of children who are direct and indirect victims. The impact of torture in this context must also be seen in families and the second generation.

Pain

Chronic pain is a further aspect of torture sequels in which detailed information and understanding are still lacking, probably because of the heterogeneous range of torture techniques applied. Physical and psychological levels of pain are frequently linked and are difficult to distinguish in practice. Pain in evaluation or rehabilitation could be a trigger for trauma-related flashbacks.

In one of the few studies so far, Thomsen *et al.* [34] examined 18 male survivors of torture presenting at a specialized treatment centre. Whereas all patients suffered from nociceptive and neuropathic pain, neuropathic pain was related to four specific common forms of torture (Palestinian hanging, falanga, beating and kicking of the head, and positional torture). Palestinian hanging was associated with brachial plexus injuries.

The role of physicians

Physicians are frequently in a difficult situation that might conflict with professional standards. Although the direct involvement in the development and application of physical or psychological torture is usually seen as clearly unethical [4], other situations such as asylum hearings and forensic expertise on survivors are critical areas. Open or indirect prejudice or external pressure might compromise physicians to avoid adequate examinations or treatment, even when no direct physical danger to the physician is involved, as demonstrated by Petersen *et al.* [35••] in a study on alleged torture in police custody in Spain. The examination of injuries and practices suggestive of torture by police or government-employed physicians should therefore be controlled by independent physicians selected by the detainee or his legal aid.

Treatment

Treatment before or supporting evaluation might be a special need that must be addressed to avoid re-traumatization and also to permit enhanced memory

recall, avoiding distortion by psychological defence patterns in some cases. In spite of several descriptive and case reports [36,37•], controlled outcome research is still nearly non-existent with regard to the sequels of torture. Exposure, cognitive behaviour therapy [38•], and selective serotonin re-uptake inhibitor antidepressants [39] have been demonstrated to be effective in the treatment of PTSD after social violence, but the complex nature of torture-related and unrelated factors might require adaptations in the treatment approach. In an interesting but limited single case study with a torture survivor, Fernandez *et al.* [37•] demonstrated pre-treatment regional cerebral blood flow with increased activity in the cerebellum, precuneus and supplementary motor cortex. The changes normalized after the administration of a selective serotonin re-uptake inhibitor.

Testimony therapy, as published recently by Weine *et al.* [40], can be seen as being related to forensic procedures in creating a witness statement against the perpetrator, based on personal experience, and stressing the dignity of the survivor.

Conclusion

Torture itself consists of heterogeneous psychological and physical stressors, which are usually intended to cause short and long-term suffering in different forms. The large number of factors found in the different aspects of this probably most cruel form of social violence have been well demonstrated in recent studies, and must be referred to in forensic psychiatry. Future research is needed especially with regard to the use of neurophysiological and neuroradiological assessment, but also in a more comprehensive model of sequels reflecting the cultural expression of suffering and an extended concept of post-traumatic spectrum disorders. As torture and the situation of survivors are frequently embedded in critical political situations, the role of the physician has to stand up to clearly defined ethical standards. Besides the possibility of being a collaborator in the act of torture or the covering up of sequels, psychiatrists conducting forensic assessment need to take special care and respect to avoid re-traumatization or insufficient findings.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- • of special interest
- •• of outstanding interest

1 Ahmad K. Amnesty report paints a grim picture of torture around the world. Lancet 2000; 356:1503.

2 United Nations General Assembly. Convention against torture and other cruel, inhuman or degrading treatment or punishment. New York, NY: UN; 1987.

3 Basoglu M, Paker M, Paker O, *et al.* Psychological effects of torture: a comparison of tortured with nontortured political activists in Turkey. Am J Psychiatry 1994; 151:76–81.

4 Helmchen H, Okasha A. From the Hawaii Declaration to the Declaration of Madrid. Acta Psychiatr Scand Suppl 2000; 399:20–23.

5 Wenzel T, Griengl H, Stompe T, *et al.* Psychological disorders in survivors of torture: exhaustion, impairment and depression. Psychopathology 2000; 33:292–295.

6 Eitinger L. Jewish concentration camp survivors in the post-war world. Danish Med Bull 1980; 27:292–295.

7 •• Van Ommeren M, de Jong JT, Sharma B, *et al.* Psychiatric disorders among tortured Bhutanese refugees in Nepal. Arch Gen Psychiatry 2001; 58:475–482.
An important study, using a large population sample, structured interviews, a control group, and an evaluation not only of PTSD, but also of other important torture-related disorders.

8 • Silove D, Steel Z, McGorry P, *et al.* The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants. Comprehens Psychiatry 2002; 43:49–55.
The authors developed a principal components analysis-based model to predict the symptom level. Torture was a major factor, underlining the forensic importance of torture.

9 American Psychiatric Association. Diagnostical and Statistical Manual of Psychiatric Disorders. 3rd ed. Washington, DC: American Psychiatric Association; 1980.

10 Mollica RF, Caspi Yavin Y, Bollini P, *et al.* The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. J Nerv Ment Dis 1992; 180:111–116.

11 Halepota AA, Wasif SA. Hopkins Symptoms Checklist: 25 (HSCL-25); Urdu translation: an instrument for detecting anxiety and depression in torture and trauma victims. J Pak Med Assoc 2001; 51:255–277.

12 Halepota AA, Wasif SA. Harvard Trauma Questionnaire Urdu translation: the only cross-culturally validated screening instrument for the assessment of trauma and torture and their sequelae. J Pak Med Assoc 2001; 51:285–290.

13 •• Van Ommeren M, Sharma B, Komproe I, *et al.* Trauma and loss as determinants of medically unexplained epidemic illness in a Bhutanese refugee camp. Psychol Med 2001; 31:1259–1267.
The authors present a case–control study, comparing conversion symptoms as part of an unexplained epidemic, demonstrating the importance of cultural factors and bereavement in the aetiology and expression of distress, which should be part of a comprehensive assessment.

14 • Tang SS, Fox SH. Traumatic experiences and the mental health of Senegalese refugees. J Nerv Ment Dis 2001; 189:507–512.
The study uses a simple methodological approach and confirms findings of earlier studies, indicating high levels of distress in refugees exposed to different stressors including torture.

15 Iacopino V, Ozkalipci O, Sahar C. The Istanbul Protocol: international standards for the effective investigation and documentation of torture and ill treatment. Lancet 1999; 354:1117.

16 • Moreno A, Grodin MA. Torture and its neurological sequelae. Spinal Cord 2002; 40:213–229.
Moreno and Grodin present a review of possible neurological sequels, which underlines the need for neurological assessment in survivors, based on a Medline search.

17 • Weinstein CS, Fucetola R, Mollica R. Neuropsychological issues in the assessment of refugees and victims of mass violence. Neuropsychol Rev 2001; 11:131–141.
The authors offer an overview of the complex factors interacting with brain trauma, proposing the inclusion of neuropsychologists in the assessment of survivors.

18 • Scandergaard HP, Ekblad S, Theorell T. Self-reported life event: patterns and their relation to health among recently resettled Iraqi and Kurdish refugees in Sweden. J Nerv Ment Dis 2001; 189:838–845.
One of the few recent longitudinal studies demonstrates the impact of life events in the host country and also of political events on psychiatric symptoms, with an especially strong influence in PTSD patients.

19 Priebe S, Esmaili S. Long-term mental sequelae of torture in Iran – who seeks treatment? J Nerv Mental Dis 1997; 185:74–77

20 Gorst-Unsworth C, Goldenberg E. Psychological sequelae of torture and organised violence suffered by refugees from Iraq: trauma-related factors compared with social factors in exile. Br J Psychiatry 1998; 172:90–94.

21 Hanigsberg N, Folnegovic-Smalc V, Moro L. Stressor characteristics and post-traumatic stress disorder symptom dimensions in war victims. 2001; 42:543–500.

One of the few studies that presents some of the mine of data from the war in former Yugoslavia, demonstrating different symptom clusters in tortured prisoners of war and other groups.

22 Iacopino V, Frank MW, Bauer HM, et al. A population-based assessment of human rights abuses committed against ethnic Albanian refugees from Kosovo. Am J Public Health 2001; 91:2019–2018.

A study documenting the frequency of different forms of persecution that surround torture, and indicate the need for a comprehensive assessment of all traumatic factors.

23 Roncevic GI, Franciskovic T, Moro L, Kasealan A. Depression and torture. Mil Med 2001; 166:530–533.

The authors compared groups of torture survivors from other war survivors. Torture was the most significant factor to predict symptom levels.

24 Shrestha NM, Sharma B, Van Ommeren M, et al. Impact of torture on refugees displaced within the developing world: symptomatology among Bhutanese refugees in Nepal. JAMA 1998; 280:443–448.

25 de Jong JT, Komproe IH, Van Ommeren M, et al. Lifetime events and posttraumatic stress disorder in 4 postconflict settings. JAMA 2001; 286:555–562.

An especially interesting study, as the design permitted the authors to compare the frequency of traumatic events, including torture, with environmental factors in different ethnic and religious groups.

26 Burnett A, Peel M. What brings asylum seekers to the United Kingdom? BMJ 2001; 322:485–488.

27 Cohen H, Benjamin J, Geva AB, et al. Autonomic dysregulation in panic disorder and in post-traumatic stress disorder: application of power spectrum analysis of heart rate variability at rest and in response to recollection of trauma or panic attacks. Psychiatry Res 2000; 96:1–13.

28 McDonagh Coyle A, McHugo GJ, Friedman MJ, et al. Psychophysiological reactivity in female sexual abuse survivors. J Trauma Stress 2001; 14:667–683.

This study demonstrates again how case-specific and PTSD-specific changes can be traced using present psychophysiological methodology. A study of relevance for the assessment of sequels, if care is taken to avoid undue stress.

29 Shaw ME, Strother SC, McFarlane AC, et al. Abnormal functional connectivity in posttraumatic stress disorder. Neuroimage 2002; 15:661–674.

The authors used PET and specific statistical methods, including covariance-based multivariate analysis to investigate distributed brain systems in PTSD patients and matched controls. This is not only a good example for the application of neuroradiological methods, but also demonstrates significant and specific working-memory difficulties that are of possible relevance for evaluation.

30 Pross C. The police medical service of Berlin: doctors or agents of the State? Lancet 2000; 356:1435–1436.

31 Montgomery E, Foldspang A. Criterion-related validity of screening for exposure to torture. Dan Med Bull 1994; 41:588–591.

32 Petersen HD, Wandall JH. Evidence of physical torture in a series of children. Forens Sci Int 1995; 75:45–55.

33 Montgomery E, Foldspang A. Traumatic experience and sleep disturbance in refugee children from the Middle East. Eur J Public Health 2001; 11:18–22.

The authors have over the past few years specialized in direct and indirect studies in children. This area merits major future research efforts. This is well designed and relevant.

34 Thomsen AB, Eriksen J, Smidt Nielsen K. Chronic pain in torture survivors. Forens Sci Int 2000; 108:155–163.

35 Petersen HD, Moreno B, Calleja LF, et al. Assessment of the quality of medical documents issued in central police stations in Madrid, Spain: the doctor's role in the prevention of ill-treatment. J Forens Sci 2002; 47:293–298.

The authors for the first time succeeded in demonstrating the covering up of sequels by physicians in a present-day European country.

36 Nieves Grafals S. Brief therapy of civil war-related trauma: a case study. Cultur Divers Ethn Minor Psychol 2001; 7:387–398.

37 Fernandez M, Pardoe A, Fares O, et al. Brain function in a patient with torture related post-traumatic stress disorder before and after fluoxetine treatment: a positron emission tomography provocation study. Neurosci Lett 2001; 297:101–104.

Most studies with torture survivors at present follow a single case approach. The use of PET imaging to measure baseline changes and therapy results is unique not only with regard to torture survivors.

38 Paunovic N, Ost LG. Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. Behav Res Ther 2001; 39:1183–1197.

An example of the still rare controlled therapy outcome research after torture and war-related trauma.

39 Hageman I, Andersen HS, Jorgensen MB. Post-traumatic stress disorder: a review of psychobiology and pharmacotherapy. Acta Psychiatr Scand 2001; 104:411–422.

40 Weine SM, Kulenovic AD, Pavkovic I, Gibbons R. Testimony psychotherapy in Bosnian refugees: a pilot study. Am J Psychiatry 1998; 155:1720–1726.

Stability of recall of military hazards over time

Evidence from the Persian Gulf War of 1991

S. WESSELY, C. UNWIN, M. HOTOPF, L. HULL, K. ISMAIL, V. NICOLAOU and A. DAVID

Background Wartime traumatic events are related to subsequent psychological and physical health, but quantifying the association is problematic. Memory changes over time and is influenced by psychological status.

Aims To use a large, two-stage cohort study of members of the UK armed forces to study changes in recall of both traumatic and 'toxic' hazards.

Method A questionnaire-based follow-up study assessed 2370 UK military personnel repeating earlier questions about exposure to military hazards.

Results The κ statistics for reporting of hazards were good for some exposures, but very low for others. Gulf veterans reported more exposures over time (no significant rise in the Bosnia cohort). In the Gulf cohort only, reporting new exposures was associated with worsening health perception, and forgetting previously reported exposures with improved perception. We found no association between physical health, psychological morbidity or post-traumatic stress disorder symptoms and endorsement or non-endorsement of exposures.

Conclusions Reporting of military hazards after a conflict is not static, and is associated with current self-rated perception of health. Self-report of exposures associated with media publicity needs to be treated with caution.

Declaration of interest None. Funding detailed in Acknowledgements.

It is known that there is an association between traumatic event reporting and negative health outcomes, particularly post-traumatic stress disorder (PTSD) (Kaylor *et al*, 1987; Brewin *et al*, 2000). However, establishing the nature and magnitude of this association has been difficult, resulting in very different estimates. Most studies of the link between adversity and health are cross-sectional and rely on retrospective accounts of events and circumstances. There is consensus that retrospectively recalled accounts of trauma are problematic, and potentially subject to a variety of recall biases, but there is no consensus as to either the size of the problem or its implications (McFarlane, 1988).

Several studies have looked at the relationship between retrospective recall of exposures at several time points and their relationship to health outcomes, mainly PTSD. We have conducted a large-scale longitudinal study of the health of UK military personnel, based on three cohorts: those who saw service in the 1991 Persian Gulf conflict, those who were deployed on peacekeeping operations in Bosnia between 1991 and 1997, and those who were in the forces at the time of the 1991 Gulf conflict but were not deployed (Unwin *et al*, 1999). We now report on the results of a follow-up study, in which the same questions about specific military exposures related to the deployments on which the respondents had served were asked again. In this paper we examine the consistency of reporting of military traumas and hazards over the period. We also look at the predictors of any observed change in recall of traumatic events. In particular, we test the hypothesis that psychological distress prospectively increases the recall of traumatic events and hazards over time. This study is unique in that it permits the comparison of exposure consistency for both the Gulf War and the Bosnia deployments. We are thus able to compare the recall of military exposures relevant to both fighting and peacekeeping.

METHOD

A follow-up descriptive study examined the health status of a stratified sample of participants who had completed the first phase of the King's College London epidemiological health survey of military personnel (Unwin *et al*, 1999). The original study took place in 1997, which was 6 years after the end of the Gulf War, and 5 years after the start of the Bosnia deployment. This survey was succeeded by a series of detailed clinical case–control studies (stage 2: David *et al*, 2002; Higgins *et al*, 2002; Sharief *et al*, 2002). The follow-up study, stage 3, took place in 2000 and 2001, approximately 3 years later. During the follow-up study, participants were asked again about specific military exposures related to the deployments on which they had served. In this paper we compare responses between the two large epidemiological surveys of the same personnel at stage 1 and stage 3.

Participants

The target group was a stratified sample of the cohort who completed the stage 1 Health Survey of Military Personnel (n=8195). This cohort consisted of three groups: personnel who served in the Persian Gulf region between 1 September 1990 and 30 June 1991 (the Gulf Cohort); personnel who had served in Bosnia between 1 April 1992 and 6 February 1997 (the Bosnia cohort); and personnel who were serving in the armed forces on 1 January 1991 but who were not deployed to the Gulf conflict (the Era cohort). Special forces were excluded for security reasons. Two stratification variables were used: fatigue and gender.

We were primarily interested in examining the health of Gulf veterans. At stage 1, fatigue, along with being strongly associated with other health outcomes measured, was one of the most consistently reported symptoms in Gulf veterans, and was our *a priori* principal outcome measure, and the basis for the stratified sample strategy. In order to ensure that the most severely ill were well represented, all male veterans with a fatigue score of 9 or more (511 Gulf, 115 Bosnia and 120 Era were included). A 1:2 sample of male Gulf veterans with mid-range fatigue scores of 4–8 (484 veterans) along with all Bosnia veterans (n=333) and Era veterans (n=364) scoring in this range were selected. Finally, a 1:8 sample of veterans with fatigue scores less

than 4 was selected in order to represent asymptomatic individuals (250 in each group). All female veterans who completed the stage 1 questionnaire (n=648) were contacted, as women were oversampled in the original cohort. This also allowed us to look for any gender differences in follow-up variables. The total sample size was 3322.

Ethical approvals were obtained for all stages of the study. All respondents at stage 1 gave signed consent to later follow-up.

Questionnaire

The questionnaire mainly replicated the measures used at stage 1, including demographic details (age, gender, marital and educational status, alcohol and smoking habits), chronic fatigue scale, medical symptoms (50 items), self reported medical disorders (39 items), the 12-item General Health Questionnaire (Goldberg, 1972), and the 36-item Medical Outcomes Study Short Form (SF 36) sub-scales for physical health, health perception and functional capacity (Stewart *et al*, 1988).

As detailed in the original study report (Unwin *et al*, 1999) we created a brief measure labelled 'post-traumatic stress reaction' (PTSR). This was embedded in the wider questionnaire because we did not wish to have an overt PTSD scale, given the social context of 'Gulf War syndrome' at the time among the UK service community and also because of the need to keep measures to a minimum. Full details of this are contained elsewhere, but in essence it consisted of four simple stem questions covering the basic psychopathological features of PTSD (Unwin *et al*, 1999).

Military exposure history was investigated using the same checklist as at stage 1, again tailored for the appropriate deployment. In practice this meant that the Bosnia and Era groups were not asked about the following exposures specific to the Gulf War: smoke from oil-well fires; mustard gas or other blistering agents; having a Scud missile explode in the air or on the ground within 1 mile; hearing chemical alarms sounding; and chemical/nerve gas attack. The questionnaires were tailored according to whether the participant was still in service or not, as ascertained at stage 1.

Analyses

The reliability of the responses for each exposure at the two time points was quantified by the kappa statistic, which is a measure of the degree of non-random agreement between measurements of the same categorical variable. If the measurements agree more often than expected by chance, κ is positive; if agreement is complete, κ is 1; if they disagree more often than expected by chance, κ is negative (Last, 1995). A paired t-test was used to examine the number of endorsed exposures at the two time points.

We followed the same analytical approach to exposure measurements over two time points as Southwick *et al* (1997). For each of the exposures asked about, variables were created indicating whether the exposure was:

(a) always endorsed at both time points (YY);

(b) never endorsed at either time point (NN);

(c) endorsed at time 1 but not longer endorsed at time 2, i.e. no longer endorsed (YN);

(d) not endorsed at time 1, later to be endorsed, i.e. newly endorsed (NY).

Risk factors for number of newly endorsed and no longer endorsed exposures were explored by examining their median and interquartile range (IQR). Change in health status was examined by creating a change variable (stage 3 minus stage 1) for each health outcome. This was then used as the dependent variable when exploring the effect of newly endorsed and no longer endorsed exposures on health reporting over time. The data were analysed using the Statistical Package for the Social Sciences, version 10 for Windows.

RESULTS

Address information was not available for 15 of the original participants. Valid responses were obtained from 2370 (72%) participants: 907 Gulf (response rate 73.0%), 638 Bosnia (70.2%), 643 Era (69.5%) and 182 Bosnia and Gulf (78.4%). There were 246 (7.4%) refusers. Owing to the absence of an accurate address, 259 (7.8%) never received the questionnaire, despite three mailing attempts, giving a true rate of 78% (Gulf 79%; Bosnia 77%; Era 6.0%; Bosnia and Gulf 82%). For the purpose of analysis participants who had been deployed to both the Gulf and Bosnia were combined with the Gulf-only group, as in previous analyses of this cohort (Unwin *et al*, 1999, 2002; Ismail *et al*, 2000; Reid *et al*, 2001). Table 1 gives the distribution of demographic variables in the two study cohorts.

The mean number of reported exposures significantly increased over time for the Gulf cohort (Table 2), but the increase in the Bosnia cohort was modest and non-significant. The Pearson correlation between the number of reported events at both time points was low for both the Gulf cohort

Table 1 Demographic variables for the Gulf and Bosnia cohorts

	Gulf		Bosnia	
	n	(%)	*n*	(%)
Gender				
Male	900	(82.6)	477	(74.8)
Female	189	(17.4)	161	(25.2)
Age (years)				
Under 29	0	0	194	(30.4)
30–34	325	(29.8)	221	(34.6)
35–39	321	(29.5)	109	(17.1)
40–44	224	(20.6)	72	(11.3)
Over 45	219	(20.1)	42	(6.6)
Marital status				
Married	726	(67.1)	358	(56.8)
Living with partner	108	(10.0)	64	(10.2)
Never married	122	(11.3)	133	(21.1)
Separated	53	(4.9)	29	(4.6)
Divorced	69	(6.4)	46	(7.3)
Widowed	4	(0.4)	0	0
Alcohol use (units/week)				
None	151	(14.0)	48	(7.6)
1–3	271	(25.1)	149	(23.6)
4–10	331	(30.6)	199	(31.5)
11–20	197	(18.2)	142	(22.5)
21–30	99	(9.2)	63	(10.0)
30+	31	(2.9)	30	(4.8)

Table 2 Changes in mean number of exposures over time reported by the Gulf and Bosnia cohorts

Stage	Exposures (mean)	*n*	*t*	*r*
Gulf				
1	10.7	1089	5.7**	0.66**
3	11.5	1089		
Bosnia				
1	7.1	820	1.07†	0.57**
3	7.3	820		

**P<0.01; †P=0.29.

Table 3 Frequency of recall categories for each exposure in the Gulf and Bosnia cohorts

	Recall category[a]								
	YY		YN		NN		NY		
	n	(%)	*n*	(%)	*n*	(%)	*n*	(%)	*k*
Gulf									
Smoke from oil-well fires	698	(70.8)	23	(2.3)	208	(21.1)	57	(5.8)	0.79
Handled POW	461	(46.8)	59	(6.0)	382	(38.8)	83	(8.4)	0.71
Small arms fire	165	(16.8)	40	(4.1)	708	(72.0)	70	(7.1)	0.68
Scud missile exploding within 1 mile	241	(25.2)	66	(6.9)	574	(60.0)	74	(7.7)	0.67
Dismembered bodies	543	(54.9)	90	(9.1)	280	(28.3)	76	(7.7)	0.64
Burning rubbish/faeces	501	(51.7)	81	(8.4)	286	(29.5)	101	(10.4)	0.61
Maimed soldiers	405	(41.1)	85	(8.6)	382	(38.7)	114	(11.6)	0.60
Diesel/petrochemical fuel on skin	451	(46.8)	80	(8.3)	318	(33.0)	113	(11.7)	0.59
Witnessed anyone dying	131	(13.2)	58	(5.8)	712	(71.5)	94	(9.4)	0.54
Dead animals	260	(26.4)	104	(10.6)	496	(50.4)	124	(12.6)	0.51
Combat-related injury	38	(3.8)	28	(2.8)	899	(89.8)	36	(3.6)	0.51
NBC suits	817	(83.2)	39	(4.0)	62	(6.3)	64	(6.5)	0.49
Heard chemical alarms sounding	677	(69.8)	67	(6.9)	124	(12.8)	102	(10.5)	0.49
Depleted uranium	87	(10.2)	18	(2.1)	632	(74.0)	117	(13.7)	0.48
Chemical/nerve gas attack	54	(6.2)	28	(3.2)	718	(82.7)	66	(7.6)	0.48
Other paints/solvents	396	(41.9)	82	(8.7)	290	(30.7)	176	(18.6)	0.45
Pesticides on clothing/bedding	251	(26.6)	84	(8.9)	440	(46.7)	166	(17.6)	0.45
Food contaminated with smoke	139	(15.0)	72	(7.8)	588	(63.4)	127	(13.7)	0.44
Artillery close by	179	(18.3)	97	(9.9)	566	(57.8)	136	(13.9)	0.44
Personal pesticides	518	(54.5)	83	(8.7)	189	(19.9)	160	(16.8)	0.42
Local food	448	(47.3)	124	(13.1)	236	(24.9)	139	(14.7)	0.42
Exhaust from heaters/generators	623	(64.3)	63	(6.5)	128	(13.2)	155	(16.0)	0.40
Diesel/petrochemical fumes	690	(71.7)	55	(5.7)	93	(9.7)	124	(12.9)	0.40
Heat illness	110	(11.1)	115	(11.6)	678	(68.5)	87	(8.8)	0.39
CARC paint	163	(17.7)	61	(6.6)	500	(54.2)	198	(21.5)	0.37
Bathed in local pond/river	27	(2.7)	38	(3.8)	885	(89.3)	40	(4.0)	0.37
Bathed in/drank local water	57	(6.0)	57	(6.0)	753	(78.9)	87	(9.1)	0.36
Mustard gas	2	(0.2)	12	(1.3)	876	(95.5)	25	(2.7)	0.08
Bosnia									
Small arms fire	234	(34.7)	57	(8.4)	311	(46.1)	73	(10.8)	0.61
Witnessed anyone dying	85	(12.5)	28	(4.1)	508	(74.6)	60	(8.8)	0.58
Artillery close by	127	(18.6)	50	(7.3)	440	(64.5)	65	(9.5)	0.57
Dismembered bodies	193	(28.5)	66	(9.7)	337	(49.8)	81	(12.0)	0.55
Maimed soldiers	147	(21.7)	57	(8.4)	390	(57.5)	84	(12.4)	0.52
Diesel/petrochemical fuel on skin	308	(45.9)	59	(8.8)	202	(30.1)	102	(15.2)	0.51
Bathed in local pond/river	89	(13.2)	60	(8.9)	462	(68.5)	63	(9.3)	0.47
Heat illness	49	(7.2)	51	(7.5)	540	(79.3)	41	(6.0)	0.44
Dead animals	235	(34.8)	67	(9.9)	246	(36.4)	128	(18.9)	0.43
Bathed in/drank local water	41	(6.1)	40	(5.9)	545	(81.0)	47	(7.0)	0.41
Burning rubbish/faeces	274	(41.0)	100	(14.9)	198	(29.6)	97	(14.5)	0.40
Food contaminated with smoke	41	(6.1)	26	(3.9)	537	(79.8)	69	(10.3)	0.39
Local food	362	(54.1)	72	(10.8)	127	(19.0)	108	(16.1)	0.39
Other paints/solvents	255	(38.1)	66	(9.9)	191	(28.5)	158	(23.6)	0.34
Handled POW	116	(17.3)	78	(11.7)	363	(54.3)	112	(16.7)	0.34
Exhaust from heaters/generators	458	(68.0)	55	(8.2)	64	(9.5)	97	(14.4)	0.32
Pesticides on clothing/bedding	82	(12.3)	50	(7.5)	405	(60.8)	127	(19.1)	0.31
Diesel/petrochemical fumes	434	(64.5)	48	(7.1)	69	(10.3)	120	(17.8)	0.30

(continued)

Table 3 (continued)

	Recall category[1]								
	YY		YN		NN		NY		
	n	(%)	n	(%)	n	(%)	n	(%)	κ
Bosnia (continued)									
Personal pesticides	206	(31.0)	77	(11.6)	217	(32.7)	163	(24.5)	0.29
Combat-related injury	14	(2.0)	27	(4.0)	596	(87.3)	46	(6.7)	0.22
CARC paint	18	(2.7)	31	(4.7)	538	(81.5)	73	(11.1)	0.18
NBC suits	3	(0.4)	13	(1.9)	606	(90.6)	47	(7.0)	0.06
Depleted uranium	1	(0.0)	10	(0.5)	618	(98.4)	17	(0.8)	0.05

CARC, chemical agent resistant coating; NBC, nuclear, biological and chemical; POW, prisoners of war.
1 YY, endorsed at both time points; NN, not endorsed at either time point; YN, no longer endorsed; NY, not endorsed at time 1, endorsed at time 2.
2 Denominator used for percentages is total n for each exposure.

and Bosnia cohort (κ=0.66 and 0.57 respectively). Table 3 shows the percentage responses of YY, NN, YN and NY, along with the κ values, for each of the variables in the questionnaires given to the Gulf and Bosnia cohorts. In the Gulf cohort the most reliably recalled exposures were: smoke from oil well fires (κ=0.79); handled prisoners of war (κ=0.71); small arms fire (κ=0.68); Scud missile exploding within 1 mile (κ=0.67); and seeing dismembered bodies (κ=0.64). For the Bosnia cohort the most reliably recalled exposures were: small arms fire (κ=0.61); witnessing anyone dying (κ=0.58); artillery close by (κ=0.57); seeing dismembered bodies (κ=0.55); and diesel or petrochemical fuel on skin. For the 24 exposures common to the two cohorts, the Gulf cohort had higher κ values for all except 4 (bathed in/drank local water; bathed in local pond/river; heat illness; and witnessed anyone dying).

On average the Gulf cohort had more newly endorsed (NY) than no longer endorsed (YN) exposures (mean NY=2.90, s.d.=2.39; mean YN=1.80, s.d.=1.75), a pattern repeated in the Bosnia cohort (mean NY=2.89, s.d.=2.36; mean YN=1.74, s.d.=1.78) and indicating an overall rise in the number of exposures recalled over time (Table 4). Table 5 gives the risk factors for numbers of newly endorsed and no longer endorsed exposures. For the number of no longer endorsed items, the most significant risk factor was serving status, with those in service having a higher median value for no longer endorsed exposures than those not in service. This pattern held for both the Gulf and Bosnia cohorts. For the newly endorsed exposures over time, being male and younger were associated with higher median values for both the Gulf and Bosnia cohorts, whereas living with a partner was associated with a higher median value in the Bosnia cohort only.

Table 4 Frequency of newly endorsed ('no to yes') and no longer endorsed ('yes to no') exposure recall in the Gulf and Bosnia cohorts

Number of changes	Gulf				Bosnia			
	Yes to no		No to yes		Yes to no		No to yes	
	n	(%)	n	(%)	n	(%)	n	(%)
0	260	(25.6)	131	(13.0)	195	(28.4)	93	(13.6)
1	261	(25.9)	204	(20.3)	177	(25.8)	123	(17.9)
2	209	(20.8)	183	(18.2)	142	(20.7)	145	(21.1)
3	118	(11.7)	151	(15.0)	70	(10.2)	100	(14.6)
4	89	(8.8)	123	(12.2)	46	(6.7)	79	(11.5)
5	33	(3.3)	86	(8.5)	27	(3.9)	58	(8.5)
6	20	(2.0)	46	(4.6)	14	(2.0)	28	(4.1)
7	6	(0.6)	32	(3.2)	7	(1.0)	21	(3.1)
8	6	(0.6)	24	(2.4)	4	(0.6)	19	(2.8)
9	1	(0.1)	10	(0.4)	2	(0.3)	12	(1.7)
10	2	(0.2)	8	(0.8)	2	(0.3)	1	(0.1)
11	–		3	(0.3)	–		5	(0.7)
12			1	(0.1)			1	(0.1)
13			1	(0.1)			1	(0.1)
14			1	(0.1)				
15			2	(0.2)				
16	1	(0.1)	–		–		–	

Table 6 shows the mean changes in health outcomes for the Bosnia and Gulf cohorts and their association with newly endorsed or no longer endorsed exposures. For the purpose of these analyses, the no longer endorsed (YN) and newly endorsed (NY) exposure recall variables have been recoded to combine the tailed distribution into one group. There was a pattern of increased (i.e. improved) health perception and increased no longer endorsed (i.e. forgotten) exposures over time in the Gulf cohort, which was not replicated in the Bosnia cohort. Conversely, there was a pattern of worsening health perception and increasing new endorsement of exposure variables over time in the Gulf cohort but not the Bosnia cohort. There was no discernible pattern of association between

Table 5 Association between demographic factors and exposure change variables (YN, no longer endorsed; NY, newly endorsed)

	Gulf							Bosnia						
		YN			NY				YN			NY		
	n	Median	IQR	P	Median	IQR	P	n	Median	IQR	P	Median	IQR	P
Gender				0.35			0.02[1]				0.17			<0.01[1]
Male	839	1.0	3.00		3.0	3.00		552	1.0	3.00		3.0	3.00	
Female	167	1.0	3.00		2.0	3.00		134	1.0	2.00		2.0	2.00	
Age (years)				0.12[2]			0.01[2]				0.90[2]			<0.01[2]
Under 29	0	–	–		–	–		168	1.0	2.00		3.0	3.00	
30–34	306	1.0	3.00		3.0	3.00		272	1.0	3.00		2.0	3.00	
35–39	299	1.0	2.00		3.0	3.00		117	2.0	3.00		2.0	3.00	
40–44	206	1.0	2.00		2.0	3.00		87	1.0	1.00		2.0	3.00	
Over 45	195	2.0	2.00		2.0	3.00		42	1.5	3.00		2.0	3.25	
Marital status				0.67[2]			0.09[2]				0.55[2]			0.04[2]
Married	667	1.0	3.00		2.0	3.00		407	1.0	3.00		2.00	3.00	
Living with partner	105	2.0	2.00		3.0	4.00		76	1.0	2.00		3.0	3.00	
Never married	112	1.0	2.00		2.0	3.00		118	1.0	2.00		2.0	4.00	
Separated	50	2.0	2.00		3.0	4.00		32	1.0	1.00		2.0	2.75	
Divorced	61	2.0	2.50		3.0	3.00		44	1.0	3.00		2.0	3.00	
Widowed	4	1.5	2.50		3.0	4.25		0	–	–		–	–	
Serving status				0.03[1]			0.41[1]				0.00[1]			0.68
Still serving	347	2.0	2.00		3.0	3.00		416	2.0	3.00		2.0	3.00	
Not serving	642	1.0	2.00		2.0	3.00		251	1.0	2.00		2.0	3.00	

IQR, interquartile range.
1. Mann–Whitney U test for rank difference.
2. Kruskal–Wallis test for rank difference.

physical health, psychological morbidity or PTSD symptoms (PTSR) and endorsement or non-endorsement of exposures, for either the Gulf or the Bosnia cohort. These analyses were repeated for the Gulf cohort, omitting the five Gulf-specific exposures (smoke from oil-well fires; mustard gas or other blistering agents; having a Scud missile explode in the air or on the ground within 1 mile; chemical/nerve gas attack; and hearing chemical alarms sounding), with no difference in findings (Table 7).

Table 8 shows the regression analyses results for the effects of newly endorsed ('newly remembered') and no longer endorsed ('forgotten') exposures on health, controlling for age, gender and number of endorsed exposures at stage 1. For the Gulf cohort, the total of newly endorsed exposures was associated with a reduction in health perception and increased psychological morbidity, whereas the total of no longer endorsed exposures was significantly associated with improved health perception. This pattern was not replicated in the Bosnia cohort (data not shown).

DISCUSSION

We already know that there is poor agreement between reporting of military events and contemporaneous records of the same events (Keane *et al*, 1989). In an ideal world we would have objective, independent, contemporary records of exposures and hazards, but this is rarely (if ever) possible, given the 'friction' of war, and the impossibility of monitoring all hazards, both known and unknown, at the time. For that reason it is likely that self-report of hazards and exposures will continue to be the basis of the assessment of the consequences of war and military deployments for the foreseeable future.

Roemer *et al* (1998) documented consistent increases in reports of exposure to seven specific war-related stressors over time in a sample of 460 service personnel deployed to Somalia in a peacekeeping operation. These men and women were assessed in the first year after their return, and then 1–3 years later. At the second assessment PTSD symptoms uniquely contributed to reported exposure scores. Southwick *et al* (1997) administered on two occasions a 19-item war zone exposure questionnaire and the Mississippi Scale for Combat Related PTSD to 59 members of the National Guard who had been activated for Gulf War duty. They analysed the extent that recall and forgetting of exposures altered over time, and found that the number of 'no' to 'yes' changes was significantly and positively related to PTSD symptom severity at the later assessment. In contrast, Bramsen and colleagues, in a study of Dutch peacekeepers, did not find either an increase in reported items over time, or an association between number of changes between the first and second assessments and symptoms of PTSD (Bramsen *et al*, 2001). Meanwhile, other researchers have used the experience of the Gulf War to study consistency of

Table 6 Mean change in health outcomes categorised by no longer endorsed and newly endorsed exposures for the Bosnia and Gulf cohort

	Health perception		Physical health[1]		GHQ[2]		PTSR[3]	
	Mean	(s.d.)	Mean	(s.d.)	Mean	(s.d.)	Mean	(s.d.)
Gulf								
Total	0.8	(20.90)	−1.7	(16.00)	−0.8	(5.65)	−0.2	(1.42)
No longer endorsed (YN)								
0	−0.9	(20.71)	−3.2	(17.42)	−0.7	(6.12)	0.008	(1.39)
1	0.6	(21.83)	−1.2	(14.54)	−0.9	(5.75)	−0.2	(1.49)
2	0.2	(20.40)	−1.2	(14.67)	−1.0	(5.17)	−0.3	(1.34)
3	1.2	(20.01)	2.5	(14.12)	0.4	(5.03)	0.2	(1.33)
4 or 5	1.6	(20.32)	0.6	(19.72)	−1.5	(5.64)	−0.5	(1.46)
6+	13.8	(19.96)	2.3	(13.31)	0.0	(6.06)	0.4	(1.44)
P^4	0.01		0.33		0.67		0.01	
Newly endorsed (NY)								
0	3.8	(22.82)	−2.1	(15.92)	−1.9	(5.29)	−0.4	(1.31)
1	2.3	(20.94)	0.03	(15.58)	−0.9	(5.23)	−0.4	(1.38)
2	2.47	(19.07)	−1.7	(14.92)	−1.5	(5.03)	−0.4	(1.51)
3	1.16	(22.54)	−2.2	(18.97)	−0.5	(6.34)	−0.01	(1.43)
4 or 5	−1.27	(18.86)	−2.1	(15.20)	0.004	(5.90)	0.05	(1.33)
6+	−1.55	(22.06)	−2.6	(15.60)	−0.6	(6.01)	−0.02	(1.50)
P^4	<0.01		0.14		0.01		<0.01	
Bosnia								
Total	2.07	(22.56)	−2.97	(15.76)	0.7	(5.99)	0.04	(1.6)
No longer endorsed (YN)								
0	1.8	(22.27)	5.1	(18.09)	0.4	(6.02)	0.3	(1.64)
1	2.1	(22.20)	3.1	(15.36)	0.7	(6.13)	0.04	(1.63)
2	2.2	(22.47)	0.7	(13.19)	1.2	(6.34)	0.1	(1.33)
3	0.7	(24.19)	3.4	(14.66)	1.1	(5.15)	0.3	(1.70)
4 or 5	−4.4	(21.50)	−3.1	(15.12)	−0.007	(5.25)	0.2	(1.61)
6+	−0.5	(26.74)	2.5	(15.40)	−2.1	(6.94)	−0.7	(1.87)
P^4	0.56		0.03		0.11		0.01	
Newly endorsed (NY)								
0	0.7	(20.56)	−0.5	(13.79)	−1.3	(4.64)	−0.3	(1.59)
1	1.5	(22.98)	−3.0	(16.20)	−0.6	(5.74)	−0.05	(1.53)
2	−4.1	(21.03)	−1.6	(12.32)	−0.8	(6.07)	0.03	(1.48)
3	−5.7	(24.83)	−3.6	(17.57)	−0.6	(5.83)	0.2	(1.57)
4 or 5	4.4	(22.08)	4.9	(18.29)	0.5	(6.28)	0.2	(1.62)
6+	1.4	(23.49)	−3.9	(15.74)	−0.7	(7.24)	0.2	(1.89)
P^4	0.17		0.31		0.21		0.05	

1. Positive value indicates improvement in health.
2. General Health Questionnaire (GHQ): positive value indicates increase in psychological morbidity.
3. Post-traumatic stress reaction (PTSR): positive value indicates increase in symptoms.
4. Non-parametric test for trend.

reports of hazardous 'toxic' exposures over time (McCauley *et al*, 1999; Wolfe *et al*, 2002), but these studies did not consider the influence of psychological variables on changing patterns of recall.

We now consider two major findings. The first relates to the stability of recall of military hazards, and the second concerns the direction of any observed changes and the influence of psychosocial factors on those changes.

Stability of recall

There was relatively low agreement for reporting of war exposures over time, as shown by the majority of exposures having a κ under 0.6. In general our findings are very similar to those of the only study that used a similar design to look at consistency of recall in smaller numbers of US Gulf War veterans (McCauley *et al*, 1999). When the questions that we asked were almost identical to those asked in the US survey, the consistency of recall was likewise similar. Hence, in both studies, reporting exposure to smoke from oil fires was associated with good reliability, hearing Scuds detonate was also reasonably reliable, being aware of chemical alarms sounding was moderately reliable as was believing oneself exposed to chemical attack, whereas reporting drinking local water, exposure to chemical agent resistant coating (CARC) paint and exposure to depleted uranium was very unreliable in both studies. The recall of depleted uranium exposure is particularly problematic in the Bosnia cohort, indicated by the lowest κ value (0.05). Perhaps this is a reflection of the enormous publicity given to reports of cancers occurring in peacekeepers from several European nations that happened between the two phases of our study. Likewise, chemical exposures such as CARC paint, other paints/solvents and pesticides on clothing/bedding were associated with the greatest number of 'no' to 'yes' changes (increased recall) in both Gulf and Bosnia cohorts, and correspondingly low κ values. There has also been intense media concern over all these exposures in the British press in the past decade, including, but not restricted to, the military context.

Change in recall over time

Looking now at the general pattern of change, previous studies have shown that the mean number of events reported over time can either increase (Southwick *et al*, 1997; Roemer *et al*, 1998; King *et al*, 2000) or stay the same (Bramsen *et al*, 2001). Our study produced an increase in the number of events reported over time in the Gulf cohort, but no significant increase in the Bosnia cohort. What this illustrates is the importance of not assuming that all conflicts are the same in terms of their social and psychological impact. Results in our peacekeeping cohort are similar to those of Bramsen and colleagues looking at Dutch peacekeepers, and our Gulf results, although different

Table 7 Mean change in health outcomes categorised by newly endorsed and no longer endorsed exposures for generic military exposures in the Gulf cohort

	Health perception[1]		Physical health[2]		GHQ[2]		PTSR[3]	
	Mean	(s.d.)	Mean	(s.d.)	Mean	(s.d.)	Mean	(s.d.)
Total	0.7	(20.93)	1.6	(15.71)	0.8	(5.80)	0.2	(1.44)
No longer endorsed (YN)								
0	−0.3	(21.23)	−2.7	(16.32)	−0.7	(6.52)	−0.02	(1.47)
1	0.4	(20.88)	0.8	(15.24)	0.7	(5.44)	0.1	(1.45)
2	−0.3	(20.55)	−0.8	(14.18)	−0.9	(5.18)	−0.3	(1.35)
3	2.3	(19.71)	−2.4	(13.72)	0.8	(5.53)	−0.3	(1.30)
4 or 5	2.1	(21.26)	1.3	(19.88)	1.0	(5.59)	0.6	(1.58)
6+	18.3	(19.30)	2.3	(10.68)	−1.6	(5.66)	−0.4	(1.09)
P[4]	0.01		0.38		0.47		<0.01	
Newly endorsed (NY)								
0	2.8	(22.25)	−1.1	(14.71)	−1.2	(6.07)	−0.3	(1.43)
1	2.0	(21.22)	−0.7	(14.99)	−1.4	(5.45)	−0.4	(1.48)
2	1.7	(18.64)	−1.1	(15.42)	−0.6	(5.37)	−0.2	(1.40)
3	−1.3	(21.31)	−3.3	(18.50)	−0.3	(5.94)	−0.1	(1.49)
4 or 5	−1.4	(20.07)	−3.0	(16.18)	−0.3	(6.09)	−0.05	(1.32)
6+	−1.7	(22.02)	−1.3	(14.91)	−0.9	(6.03)	−0.2	(1.52)
P[4]	<0.01		0.06		0.12		0.01	

1. Positive value indicates improvement in health.
2. General Health Questionnaire (GHQ): positive value indicates increase in psychological morbidity.
3. Post-traumatic stress reaction (PTSR): positive value indicates increase in symptoms.
4. Non-parametric test for trend.

from those in the peacekeepers, are similar to the findings of Southwick and colleagues in US Gulf veterans. On the other hand, neither we nor Bramsen *et al* (2001) are able to confirm the substantial increase in reporting of events recorded by Roemer *et al* (1998) in US peacekeepers in Somalia. However, the US operation in Somalia was beset by difficulties, and involved rather more than peacekeeping, with periods of actual combat.

A second reason why the literature is not entirely consistent is that previous studies have been concerned with either post-traumatic type events and symptoms, or more 'toxic' hazards, but rarely with both. In our Gulf studies we have always taken a broader view of hazards and exposures, incorporating exposures such as vaccinations, smoke from oil fires, depleted uranium and so on, which are not traumatic in the customary use of the word, but certainly came to prominence after the 1991 Gulf War. This means that we included more measures of these kinds of hazards than the other studies, but conversely our measure of post-traumatic stress symptoms is less sophisticated.

Recall of exposures and current health perception

We found an association between health perception and both increased reporting and also forgetting of exposures, but this was not true of psychological morbidity or physical health. This association held for the Gulf cohort, but not for the Bosnia cohort. In general we found that the main pattern of change was of increased reporting ('no' to 'yes') rather than forgetting ('yes' to 'no').

There may be several explanations for changes in reporting of an event over time. The recall of events might simply become inflated over time; conversely, individuals might have underestimated their reports initially and later given more accurate appraisals. Over the specific interval of this study, there was considerable media attention to the Gulf War and its possible health effects. No doubt this information was incorporated to some lesser or greater degree into the participants' perspectives on their experiences of the war. The acquisition of new knowledge, from whatever source, could explain both types of changes in item endorsement: elucidating and clarifying events and circumstances that did occur but were not previously known (accounting for 'no' to 'yes' changes), and delimiting details of experiences previously held to be true (accounting for 'yes' to 'no' changes). We should also be careful not to assume that changes in reporting equate with changes in memory – it might be that events previously seen as irrelevant and not endorsed on a questionnaire have increased in importance and salience over time, perhaps because of media coverage, rather than being newly remembered. On the other hand, there is evidence from this study that the reporting of events is influenced by current health perception. We found an association between changes in endorsement – both positive and negative – of hazards, and current health perception. Remembering more exposures over time was associated with worsening perception of health; conversely, improved perception of health was associated with forgetting previously recalled exposures. This pattern held after we had removed exposures specific to the Gulf War from the analysis, indicating that the finding was not due to certain key Gulf War exposures that might be strongly associated with health. This finding was not replicated with measures of mental health in general, or PTSD symptoms in particular.

Another important finding is that the association between health perception and recall or non-recall of hazards and exposures was found in the Gulf cohort but not in the Bosnia cohort. This was not because of a differential effect of exposures only encountered in the Gulf and also the subject of intense media scrutiny, since removing these Gulf-specific exposures did not alter the association.

We draw attention to the finding that, contrary to our original predictions, change in recall of exposures was not associated with changes in post-traumatic stress symptoms, but with health perception. However, this is in keeping with our own nested case–control study in which we interviewed both ill and healthy veterans, this time using a standardised psychiatric interview to enable us to make firm diagnoses of PTSD, which was not the case in the epidemiological study. Although psychological morbidity was increased, modestly, in the Gulf

Table 8 Prediction of change in health status and psychological morbidity by newly endorsed and no longer endorsed exposure recall. Hierarchical regression analysis controlling for age, gender and exposure at time 1 for the Gulf cohort

Predictors	R	R^2	Step 1			Step 2			Step 3		
			B	s.e.	β	B	s.e.	β	B	s.e.	β
Health perception and newly endorsed (NY)											
Step 1	0.07	0.005									
Age			−0.21	0.10	−0.07*	−0.20	0.01	−0.07*	−0.25	0.10	−0.08*
Gender			−0.22	1.77	−0.00	0.12	1.85	0.00	−0.64	1.86	−0.01
Step 2	0.07	0.00									
Time 1 exposure						0.009	0.14	0.02	0.001	0.14	0.00
Step 3	0.12**	0.010**									
NY									−0.90	0.29	−0.10**
Health perception and no longer endorsed exposures (YN)											
Step 1	0.07	0.005									
Age			−0.21	0.10	−0.07*	−0.20	0.10	−0.07*	−0.24	0.10	−0.08*
Gender			0.22	1.78	−0.00	0.12	1.85	0.00	0.30	1.84	0.00
Step 2	0.07	0.000									
Time 1 exposure						0.009	0.14	0.02	0.008	0.15	0.02
Step 3	0.13**	0.011**									
YN									1.36	0.40	0.11*
Psychological morbidity and newly endorsed exposures (NY)											
Step 1	0.03	0.001									
Age			0.01	0.03	0.01	0.007	0.03	0.009	0.02	0.03	0.02
Gender			0.44	0.49	0.03	0.34	0.51	0.02	0.47	0.51	0.03
Step 2	0.04	0.002									
Time 1 exposure						0.03	0.04	0.02	0.01	0.04	0.01
Step 3	0.08	0.006									
NY									0.16	0.08	0.07*

*$P < 0.05$; **$P < 0.01$.

cohort, this was rarely due to PTSD (Ismail *et al*, 2002). This is unsurprising. The Gulf War was not particularly traumatic in the conventional sense for the coalition forces, particularly in the context of past military campaigns that were associated with high rates of classic war-related psychiatric injury. The perceived hazards of the Gulf tended to be those not usually associated with the military setting, and not encapsulated in the formulations of PTSD. Instead, most revolved around fears of environmental exposure and contamination. We have argued elsewhere that the indisputable increase in ill health seen after the Gulf War is better understood as part of the literature on unexplained symptoms and syndromes, rather than conventional PTSD. This may help to explain why changes in recall of exposures were associated more with changes in health perception than with symptoms of post-traumatic stress.

ACKNOWLEDGEMENTS

This study was funded by the US Department of Defence and the UK Medical Research Council. Neither organisation has had any input into the design, conduct, analysis or reporting of the study. The views expressed are the authors' own.

We thank all the servicemen and service women who gave freely of their time. We also thank Dr Inge Bramsen and Professor Ariel Shalev for their helpful advice.

REFERENCES

Bramsen, I., Dirkzwager, A., Van Esch, S., et al (2000) Consistency of self-reports of traumatic events in a population of Dutch peacekeepers: reason for optimism. *Journal of Traumatic Stress*, **14**, 733–740.

Brewin, C., Andrews, B. & Valentine, J. (2000) Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, **68**, 748–766.

David, A., Farrin, L., Hull, L., et al (2002) Cognitive functioning and disturbances of mood in UK veterans of the Persian Gulf War: a comparative study. *Psychological Medicine*, **32**, 1357–1368.

Goldberg, D. (1972) *The Detection of Psychiatric Illness by Questionnaire*. London: Oxford University Press.

Higgins, E., Ismail, K., Kant, K., et al (2002) Skin disease in Gulf War Veterans. *Quarterly Journal of Medicine*, **95**, 67–76.

Ismail, K., Blatchley, N., Hotopf, M., et al (2000) Do publication bias factors lead less ill UK Gulf war veterans? *Journal of Epidemiology and Community Health*, **54**, 834–838.

——, Kent, K., Brugha, T., et al (2002) The mental health of UK Gulf War veterans: phase 2 of a two-phase cohort study. *BMJ*, **325**, 576–579.

Kaylor, J., King, D. & King, L. (1987) Psychological effects of military service in Vietnam: a meta analysis. *Psychological Bulletin*, **102**, 257–271.

Keane, T., Fairbank, J., Caddell, J., et al (1989) Clinical evaluation of a measure to assess combat exposure. *Journal of Consulting and Clinical Psychology*, **1**, 53–55.

King, D., King, L., Erickson, D., et al (2000) Post traumatic stress disorder and retrospectively reported stressor exposure: a longitudinal prediction model. *Journal of Abnormal Psychology*, **109**, 624–633.

Last, J. (1995) *Dictionary of Epidemiology*. Oxford: Blackwell Science.

McCauley, L., Joos, S., Spencer, P., et al (1999) Strategies to assess validity of self-reported exposures during the Persian Gulf War. *Environmental Research Section A*, **81**, 195–205.

McFarlane, A. C. (1988) The longitudinal course of post-traumatic morbidity: the range of outcomes and their predictors. *Journal of Nervous and Mental Disease*, **176**, 30–39.

Reid, S., Hotopf, M., Hull, L., et al (2001) Multiple chemical sensitivity and chronic fatigue syndrome in UK Gulf War veterans. *American Journal of Epidemiology*, **153**, 604–609.

Roemer, L., Litz, B., Orsillo, S., et al (1998) Increases in retrospective accounts of war-zone exposure over time: the role of PTSD symptom severity. *Journal of Traumatic Stress*, **11**, 597–605.

Sharief, M., Delamont, R., Rose, M., et al (2002) Neurophysiologic evaluation of neuromuscular symptoms in UK Gulf War veterans: A controlled study. *Neurology*, **59**, 1318–1325.

Southwick, S., Morgan, C., Nicolaou, A., et al (1997) Consistency of memory for combat-related traumatic events in veterans of Operation Desert Storm. *American Journal of Psychiatry*, **154**, 173–177.

Stewart, A., Hays, R. & Ware, J. (1988) The MOS Short-form General Health Survey: reliability and validity in a patient population. *Medical Care*, **26**, 724–732.

Unwin, C., Blatchley, N., Coker, W., et al (1999) The health of United Kingdom servicemen who served in the Persian Gulf War. *Lancet*, **353**, 169–178.

——, Hull, L., Ismail, K., et al (2002) Women in the Persian Gulf: lack of gender differences in long-term health effects of service in United Kingdom Armed Forces in the 1991 Persian Gulf War. *Military Medicine*, **167**, 406–411.

Wolfe, J., Proctor, S., Erickson, D., et al (2002) Risk factors for multisymptom illness in US Army veterans of the Gulf War. *Journal of Occupational and Environmental Medicine*, **44**, 771–781.

CLINICAL IMPLICATIONS

- Stability of recall of hazardous exposures during military operations differs according to the nature of the exposure – those extensively publicised in the media are particularly problematic.
- The number of exposures recalled has increased with the passage of time.
- The total number of hazardous exposures reported may reflect not only actual exposures but also current distress.

LIMITATIONS

- All military conflicts differ in various ways – it cannot be assumed that these findings extrapolate beyond the 1991 Gulf War.
- The measurement of self-reported exposures was fairly crude.
- Measurement of post-traumatic symptoms was by self-report and not by structured interview.

S. WESSELY, FRCP, C. UNWIN, MSc, M. HOTOPF, PhD, L. HULL, BSc, K. ISMAIL, MRCPsych, V. NICOLAOU, BSc, A. DAWID, MD, King's Centre for Military Health Research, King's College London, UK

Correspondence: Professor S. Wessely, Department of Psychological Medicine, GKT School of Medicine, 103 Denmark Hill, London SE5 8AF, UK. E-mail: s.wessely@iop.kcl.ac.uk

(First received 15 January 2002, final revision 22 April 2002, accepted 6 May 2002)

G. Ethical and legal aspects of torture medicine – An Indian scenario

Dr. K. Mathiharan, M. D. (Forensic Medicine) Ph.D.
Hon. Advisor, Institute of Legal Medicine

Introduction

Physicians have served as actual torturers in Chile and elsewhere; have surgically removed ears as punishment for desertion in Saddam Hussein's Iraq; have incarcerated political dissenters in mental hospitals, notably in the Soviet Union; have, as whites in South Africa, falsified medical reports on blacks who were tortured or killed; and have, as Americans associated with the Central Intelligence Agency, conducted harmful, sometimes fatal, experiments involving drugs and mind control.[1]

There is increasing evidence that U.S. doctors, nurses, and medics have been complicit in torture and other illegal procedures in Iraq, Afghanistan, and Guantanamo Bay. American doctors at Abu Ghraib and Guantanamo Bay have failed to report to higher authorities wounds that were clearly caused by torture and that they have neglected to take steps to interrupt this torture. In addition, they have turned over prisoners' medical records to interrogators who could use them to exploit the prisoners' weaknesses or vulnerabilities. It is not yet learned the extent of medical involvement in delaying and possibly falsifying the death certificates of prisoners who have been killed by torturers.[2]

Generally, torture is inflicted on a person as a means of intimidation by the authorities either to subdue him or to create awfulness in the mind of a subordinate by his superior. Torture elicits pain and it is presumed by the torturer that a person under duress caused by the pain will spill the truth. Therefore, most often, torture is used by the crime investigating authorities to extract confession from the suspects.

Often medical practitioners are the earliest unbiased persons that a victim of torture comes across after the incident of torture. In such situations, medical practitioners are not only expected to treat the victim but also to document the nature of the injuries properly since this documentation will help the judiciary to arrive at a just conclusion when the issue is taken up for trial later.

Even though, Indian Medical Association started a diploma course in Torture Medicine way back in 1994, many medical practitioners are still unaware of the medical aspects of torture and their crucial role in treating the victims, giving witness in a court of law and in preventing such incidents.

Definition of Torture

In 1975, World Medical Association brought out the Declaration of Tokyo, which defines torture as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

The Declaration on the Protection of all Persons from being subjected to Torture and other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment[3] are the two instruments within the UN system that contain a definition of 'torture'.[4] It is defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted in order to obtain a confession, to punish or to intimidate in cases where such suffering is inflicted with the connivance of a public official. Pain and suffering arising from lawful punishments are excluded. In order for such an act to come within the formal definition, it must be degrading and inhuman treatment used for a specific purpose, such as extracting information. In addition:

- mental or physical suffering has to be caused;
- the suffering has to be grave and intentional;
- the suffering must appear unjustified in relation to the situation.[5]

The Inter-American Convention to Prevent and Punish Torture says that 'torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.'[6] This indicates the possibility that torture need not invariably entail grave physical suffering although the term is commonly used very loosely to describe any act of deliberate brutality and to convey an impression of extreme pain. The British Medical Association (BMA) has referred to all serious forms of cruel, inhuman or degrading treatment – whether or not inflicted with official connivance – as equivalent to torture. BMA definition also includes any 'deliberate, systematic or wanton infliction of physical or mental suffering ... for any reason which is an outrage on personal dignity'.[7] By this standard, issues such as forcible sterilisation and abuse within institutional settings clearly come within the remit of torture.[8]

Codes on Human Rights and Torture

In Article 5 of the Universal Declaration of Human Rights, it is stated that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Realising the crucial role played by the medical practitioners in treating the victims of torture, Medical Council of India in its latest Code of Medical Ethics[9] explicitly states that the violation of human rights by a medical practitioner is an unethical act.[10]

In 1976, the World Medical Association drafted the Tokyo Declaration, which dealt with the role of physicians in treating the prisoners and victims of custodial violence. Also, the UN General Assembly in December 1989 endorsed the resolution 1989/65 adopted by the United Nation's Economic and Social Council, on the prevention of extra judicial executions and adequate investigation of such executions. This manual is also known as the Model Minnesota Protocol for a Legal Investigation of Extra-legal, Arbitrary and Summary Executions and Model Autopsy Protocol.

In 1991, World Medical Association adopted the Declaration of Malta on Hunger Strikers and editorially revised it at Marbella, Spain in 1992. In 1997, World Medical Association adopted the declaration of Hamburg concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment.

In 1990, World Medical Association passed a resolution on human rights at Rancho Mirage, California, USA, and amended it at Budapest, Hungary, in 1993 and at Stockholm, Sweden, in 1994 and at Bali, Indonesia, in 1995. In 1999, World Medical Association at Tel Aviv, Israel passed a resolution on the inclusion of Medical Ethics and Human Rights in the curriculum of medical schools world-wide.

Torture in Ancient India

Kautilya's *Arthashastra* states that only those about whom there is a strong presumption of guilt shall be tortured to elicit a confession. It also gives a list of persons who should and should not be tortured. (4.8.14,17-20,25-27) According to *Arthashastra*, there are eighteen methods of torture – four for ordinary offences and fourteen for serious offences. The four ordinary ones are:

- six strokes with a stick
- seven lashes with a whip
- suspending twice by the arms tied together from above
- the water tube (pouring salt water through the nose)

The fourteen kinds of torture for serious offences are:

- nine strokes with a cane
- twelve lashes with a whip
- tying the right leg to the head
- tying the left leg to the head
- twenty strokes with a stick
- thirty two slaps
- tying the right hand and foot at the back
- hanging from above by the arms
- hanging from above by the feet
- pricking with a needle under the finger nails
- burning one of the joints of a finger after being made to drink gruel
- making one stand in the sun for a day after being made to drink oil
- making one lie on a bed of *balbaja* points

The instruments to be used, the conditions, the methods of infliction, the duration and the termination of torture shall be ascertained from the appropriate manual. (4.8.21-24)[11]

Another means of ascertaining guilt was the ordeal, which could be used in both civil and criminal cases. Several ordeals are mentioned including ordeals by fire and immersion. Specially interesting is the ordeal of the ploughshare, in which the accused man had to touch a red-hot iron ploughshare with his tongue; if he was not burned he was deemed innocent – psychologically a fairly sound test of his own confidence in the result, since if he had a guilty conscience his salivary glands would not function properly, and his tongue would be burnt.[12]

In British India, the early incidence of custody death was reported in Madras in 1678. Subsequent to a drunken brawl abused his superior officer, Thomas Savage, a soldier, was tied to the cot and his neck and heels with hands behind and knees on shoulders were bound. Because of this, he died his body was examined by Surgeons John Waldo (Surgeon) and Bezaliel Sherman (Second Surgeon). Based on the apparent marks of binding around his neck, they opined that it was the cause of his death.[13]

Human Rights Act 1993[14]

The growth and evolution of Human Rights and International Law had achieved a remarkable progress since the year 1948. The Constitution of India also facilitated the impact of the evolution of the concept of human rights and its dissemination to every segment of the society in India and the elected bodies and the judiciary took up the vigorous implementation of the rights enshrined in it.

In India, the Protection of Human Rights Act, 1993[15] was enacted to provide for the constitution of a National Human Rights Commission, State Human Rights Commissions in States and Human Rights Courts for better protection of human rights and for matters connected therewith or incidental thereto.

India is a party to the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. In *People's Union for Civil Liberties v. Union of India*,[16] it was held by the Supreme Court that Article 21 of the Constitution of India in relation to human rights has to be interpreted in conformity with International Law. Further, Article 25 (2) of Universal Declaration of Human Rights and Article 7 (b) of the International Covenant on Economic, Social and Cultural Rights have been cited by the Apex Court while upholding the right to health by a worker.[17]

These Covenants find statutory acceptance in the Statement of Objects and Reasons of The Protection of Human Rights Act, 1993, which defines in Section 2 (f) that International Covenants mean International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights adopted by the General Assembly of the United Nations on December 16, 1966. In addition, the Human Rights Commissions are empowered to study treaties and other international instruments on human rights and make recommendations for their effective implementation.[18]

In the recent past, many complaints of alleged medical negligence and deficient service by the private and government hospitals and medical professionals are filed either at National Human Rights Commission or State Human Rights Commissions since right to healthcare is considered as a human right.

In *M.P. Human Rights Commission v. State of M.P.*,[19] it was held: it cannot be said by any stretch of imagination that the Human Rights Commission cannot canvass the cause of the persons who have lost their eye sight in eye camps conducted by the Blindness Control Society. The plea in regard to the *locus standi* of the petitioner would be in the realm of hyper-technicality. In the absence of disputed questions of fact and in view of the fact, the Human Rights Commission has knocked at the doors of the High Court to agitate the cause of the anguished persons, the High Court cannot shut its eyes to the factual scenario that has emerged and ask the affected parties to file appropriate application before any other legal forum for obtaining compensation. The law has marched like a Pegasus to override this kind of technical fetters.

Types of Medical Involvement in Torture[20]

- assessing torture techniques
- training others in techniques
- assessing detainees' fitness
- monitoring torture
- administering punishment
- reviving detainees
- helping torturers disguise the effects of torture
- providing treatment after torture
- providing certificates/reports
- failing to denounce known examples of torture
- assessing people who claim to have been tortured
- rehabilitation of survivors

Ethical and Legal Aspects of Torture

Freedom from torture is among the human rights contained in the United Nations' 'Universal Declaration of Human Rights'. Doctors are obliged by the Hippocratic Oath, not to use their professional knowledge in order to harm their patients. This obligation has been reconfirmed in the 'Geneva Declaration of the World Medical Association' and precludes any medical involvement in the practice of torture.

The Tokyo declaration stated that a doctor must in no way, for any reason, take part in the practice of torture or other forms of cruel, inhuman or degrading procedures as the

doctor's role is to alleviate the distress of his/her fellow persons and, 'no motive whether personal, collective or political shall prevail against this higher purpose'.

The Declaration of Malta of World Medical Association on Hunger Strikers state that the ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare. However, the doctor should clearly state to the patient whether or not he is able to accept the patient's decision to refuse treatment or, in case of coma, artificial feeding, thereby risking death. If the doctor cannot accept the patient's decision to refuse such aid, the patient would then be entitled to be attended by another physician.

The declaration of Hamburg of World Medical Association prohibited the medical doctors throughout the world from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.

The victims of torture may either suffer from injuries or may die because of injuries and therefore, such cases should be carefully and thoroughly examined, reported to the police or the magistrate and treated. A proper examination may help in establishing or disproving the charge of tortures both, during the examination of the injury and autopsy. Section 330 and 331 of the IPC deals with crime and punishment of voluntarily causing hurt and grievous hurt for the purpose of extorting confession or any information, which may lead to the detection of an offence or misconduct.

Acknowledgement

The author thanks Prof. Dr. Amrit K. Patnaik, Director, Institute of Legal Medicine and Former Director, Institute of Forensic Medicine, Madras Medical College, Chennai for his critical comments and valuable suggestions in the preparation of this paper.

References

[1] Lifton Jay Robert, Doctors and Torture N Engl J Med 351;5 July 29, 2004 415 – 416 at 416

[2] Ibid at 415

[3] In 1975, the United Nations adopted the Declaration on the Protection of all Persons from being subjected to Torture and other Cruel, Inhuman or Degrading Treatment or Punishment and in 1984, it published the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

[4] Kellberg L., 'Torture: International Rules and Procedures' in Duner, B. (ed.) (1998) *An End to Torture: Strategies for its Eradication*, Zed Books, London

[5] Rodley,N. (1987) *The Treatment of Prisoners Under International Law*, Oxford University Press, Oxford

[6] Article 2 of the Inter-American Convention to Prevent and Punish Torture, adopted December 1985, entered into force February, 1987

[7] BMA (1986) *Torture Report*, BMA, London, p.4; BMA (1992) *Medicine Betrayed*, Zed Books, London, p. xvi.

[8] *The Medical Profession and Human Rights*: Handbook for a Changing Agenda Zed Books with British Medical Association, London 2001 p. 61

[9] Section 6.6 of Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002: General Principles, The Physician's Responsibility, Medical Council of India (New Delhi, dated 11March, 2002 No. MCI-211 (2) / 2001/ Registration. In exercise of the powers conferred under section 20A read with section 33(m) of the Indian Medical Council Act, 1956 (102 of 1956)Published in Part III, Section 4 of the Gazette of India, dated 6 April, 2002)

[10] Code of Medical Ethics states as follows: The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights.

[11] Kautilya's *Arthashastra*. Ed. Rangarajan L.N. New Delhi: Penguin Books, 1992

[12] Basham A.L.: The Wonder that was India, Fontana Books in association with Rupa & Co. Calcutta 1967 page 117; Edgar Thurston: Ethnographic Notes in Southern India, Asian Educational Services, Reprint 1989

[13] Fort St. George Consultation 1678-79; Wheeler J. Talboys Madras in the Olden Times In: Mathiharan K.: Medical Profession and Human Rights, Issues in Medical Ethics, Vol. VI No. 4, October – December 1998 p. 117-118

[14] Mathiharan K.: The Fundamental Right to Health Care, Vol. XI No. 4, October – December 2003 p. 123

[15] Received the assent of the President on January 8, 1994 and published in the Gazette of India, Extra., Part II, Section I, dated 10 th January, 1994, p. 1-16, Sl.No.10

[16] 1997 (1) SCC 301

[17] *C.E.S.C. Ltd. v. Subhash Chandra Bose* ((1992) 1 SCC 441 at 462

[18] Chapter III, Section 12 (f) of The Protection of Human Rights Act, 1993

[19] AIR 2003 M.P. 17

20The Medical Profession and Human Rights: Handbook for a Changing Agenda Zed Books with British Medical Association, London 2001 at p. 69

IX. NATIONAL LEGAL REGIME IN COMBATING TORTURE

A) Relevant provisions of Indian laws

I. Status of International Treaties in Domestic Law

India is a party to many international conventions/covenants, which prohibits the acts of torture. However, there are no explicit provisions in the constitution regulating the incorporation of and status of international law in Indian legal system. But **Article 51(c)** stipulates as one of directive principles of state policy, that: *"The state shall endeavor to foster respect for international law and treaty obligations in the dealings of organized people with other".*

In this regard **Article 253** of the Constitution read as follows;

Article 253. Legislation for giving effect to international agreements.- *Notwithstanding anything in the foregoing provisions of this Chapter, Parliament has power to make any law for the whole or any part of the territory of India for implementing any treaty, agreement or convention with any other country or countries or any decision made at any international conference, association or other body.*

For the successful implementation of International laws in the domestic legal system they have to be transformed in to domestic law by the legislative act and the Union has the exclusive power in this regard under **A.253 of the** Constitution and to this end it has passed only Geneva Conventions Act, 1960.

The judicial opinion in India as expressed in numerous recent judgments demonstrates that the rules of international law should be construed harmoniously, and only when there is an inevitable conflict between these two laws should municipal law should prevail over international law .The supreme court has even gone a step further by repeatedly holding, when interpreting the fundamental rights provisions of the constitution, that those provisions of the International Covenant on Civil and Political Rights ,which elucidate and effectuate the fundamental rights guaranteed by the constitution can be relied upon by the courts as facets of those fundamental rights and are, therefore, enforceable.

The Supreme Court in ***Chairman, Railway Board v. Chandrima Das*** **(1993) 2 SCC 746** observed, the applicability of the Universal Declaration of Human Rights and principles thereof may have to be read, if need be, into the domestic jurisprudence.

In *People's Union for Civil Liberties v. Union of India, (1997) 3 SCC 433*, at page 442, the Supreme Court stated that, *"For the present, it would suffice to state that the provisions of the covenant, which elucidate and go to effectuate the fundamental rights guaranteed by our Constitution, can certainly be relied upon by courts as facets of those fundamental rights and hence, enforceable as such."*

In ***Vishaka v State of Rajasthan*** **(1997) 6 SCC 241** the Supreme Court held that it is now an accepted rule of judicial construction that regard must be had to international conventions and

norms for construing domestic law when there is no inconsistency between them and there is a void in the domestic law. In the absence of domestic law occupying the field, to formulate effective measures to check the evil of sexual harassment of working women at all work places, the contents of International Conventions and norms are significant for the purpose of interpretation of the guarantee of gender equality, right to work with human dignity in Articles 14, 15, 19(1)(g) and 21 of the Constitution and the safeguards against sexual harassment implicit therein. Any International Convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantees. This is implicit from Article 51(c) and the enabling power of the Parliament to enact laws for implementing the International Conventions and norms by virtue of Art. 253 read with Entry 14 of the Union List in Seventh Schedule of the Constitution.

In ***Apparel Export Promotion v A.K. Chopra 1999 (1) SCC 759***, the SC has stated that "In cases involving violation of human rights, the courts must remain alive to the international instruments and conventions and apply the same to a given case where there is no inconsistency between the international norms and the domestic law occupying the field."

II. Criminal accountability under statutory law

Indian Penal Code, 1860: ,

S.119. Public servant concealing design to commit offence which it is his duty to prevent

Whoever, being a public servant, intending to facilitate or knowing it to be likely that he will thereby facilitate the commission of an offence which it is his duty as such public servant to prevent;

voluntarily conceals, by any act or illegal omission, the existence of a design to commit such offence, or makes any representation which he knows to be false respecting such design;

If offence be committed- shall, if the offence be committed, be punished with imprisonment of any description provided for the offence, for a term which may extend to one-half of the longest term of such imprisonment, or with such fine as is provided for that offence, or with both;

If offence be punishable with death, etc- or, if the offence be punishable with death or [51][imprisonment for life], with imprisonment of either description for a term which may extend to ten years;

If offence be not committed-or if the offence be not committed, shall be punished with imprisonment of any description provided for the offence for a term which may extend to one-fourth part of the longest term of such imprisonment or with such fine as is provided for the offence, or with both.

Illustration A : an officer of police, being legally bound to give information of all designs to commit robbery which may come to his knowledge, and knowing that B designs to commit robbery, omits to give such information, with intent to facilitate the commission

S.166. Public servant disobeying law, with intent to cause injury to any person

Whoever, being a public servant, knowingly disobeys any direction of the law as to the way in which he is to conduct himself as such public servant, intending to cause, or knowing it to be likely that he will, by such disobedience, cause injury to any person, shall be punished with simple imprisonment for a term which may extend to one year, or with fine, or with both.

S.299. Culpable homicide

Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

S.300. Murder

Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or-

Secondly- If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or-

Thirdly- If it is done with the intention of causing bodily injury to any person and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or-

Fourthly,- If the person committing the act knows that it is so imminently dangerous that it must, in all probability, cause death or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid.

Explanation 1- A person who causes bodily injury to another who is labouring under a disorder, disease or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused his death.

Explanation 2- Where death is caused by bodily injury, the person who causes such bodily injury shall be deemed to have caused the death, although by resorting to proper remedies and skilful treatment the death might have been prevented.

Explanation 3- The causing. of the death of child in the mother's womb is not homicide. But it may amount to culpable homicide to cause the death of a living child, if any part of that child has been brought forth, though the child may not have breathed or been completely born.

S.300. Murder Exception 3-

Culpable homicide is not murder if the offender, **being a public servant** or aiding a public servant **acting for the advancement of public justice**, exceeds the powers given to him by law, and causes death by doing an act which he, in **good faith**, believes to be lawful and necessary for the due discharge of his duty as such public servant and without ill-will towards the person whose death is caused.

S.302. Punishment for murder –

Whoever commits murder shall be punished with death, or imprisonment for life, and shall also be liable to fine.

S.304. Punishment for culpable homicide not amounting to murder

Whoever commits culpable homicide not amounting to murder shall be punished with imprisonment for life, or imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine, if the act by which the death is caused is done with the intention of causing death, or of causing such bodily injury as is likely to cause death,

or with imprisonment of either description for a term which may extend to ten years, or with fine, or with both, if the act is done with the knowledge that it is likely to cause death, but without any intention to cause death, or to cause such bodily injury as is likely to cause death.

S.304A. Causing death by negligence

Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

S.319. Hurt

Whoever cases bodily pain, disease or infirmity to any person is said to cause hurt.

S.320. Grievous hurt

The following kinds of hurt only are designated as "grievous":-

First- Emasculation.

Secondly- Permanent privation of the sight of either eye.

Thirdly- Permanent privation of the hearing of either ear,

Fourthly- Privation of any member or joint.

Fifthly- Destruction or permanent impairing of the powers of any member or joint.

Sixthly- Permanent disfiguration of the head or face.

Seventhly- Fracture or dislocation of a bone or tooth.

Eighthly- Any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits.

S.321. Voluntarily causing hurt

Whoever does any act with the intention of thereby causing hurt to any person, or with the knowledge that he is likely thereby to cause hurt to any person, and does thereby cause hurt to any person, is said "voluntarily to cause hurt".

S.322. Voluntarily causing grievous hurt

Whoever voluntarily causes hurt, if the hurt which he intends to cause or knows himself to be likely to cause is grievous hurt, and if the hurt which he causes grievous hurt, is said "voluntarily to cause grievous hurt."

Explanation- A person is not said voluntarily to cause grievous hurt except when he both causes

grievous hurt and intends or knows himself to be likely to cause grievous hurt. But he is said voluntarily to cause grievous hurt, if intending or knowing himself to be likely to cause grievous hurt of one kind, he actually causes grievous hurt of another kind.

S.323. Punishment for voluntarily causing hurt.-

Whoever, except in the case provided for by section 334, voluntarily causes hurt, shall be punished with imprisonment of either description for a term which may extend to one year, or with fine which may extend to one thousand rupees, or with both.

S.350. Criminal force

Whoever intentionally uses force to any person, without that person's consent, in order to the committing of any offence, or intending by the use of such force to cause, or knowing it to be likely that by the use of such force he will cause injury, fear or annoyance to the person to whom the force is used, is said to use criminal force to that other.

S.351. Assault

Whoever makes any gesture, or any preparation intending or knowing. it to be likely that such gesture or preparation will cause any person present to apprehend that he who makes that gesture or preparation is about to use criminal force to that person, is said to commit an assault.

Explanation- Mere words do not amount to an assault. But the words which a person uses may give to his gestures or preparation such a meaning as may make those gestures or preparations amount to an assault.

S.354. Assault or criminal force to woman with intent to outrage her modesty.-

Whoever assaults or uses criminal force to any woman, intending to outrage or knowing it to be likely that he will thereby outrage her modesty, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

S.355. Assault or criminal force with intent to dishonour person, otherwise than on grave provocation.-

Whoever assaults or uses criminal force to any person, intending thereby to dishonour that person, otherwise than on grave and sudden provocation given by that person, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

S.375. Rape

A man is said to commit "rape" who, except in the case hereinafter excepted, has sexual intercourse with a woman under circumstances falling under any of the six following descriptions:-

First- Against her will.

Secondly, - Without her consent.

Thirdly- With her consent, when her consent has been obtained by putting her or any person in whom she is interested in fear of death or of hurt.

Fourthly- With her consent, when the man knows that he is not her husband, and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.

Fifthly - With her consent, when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she gives consent.

Sixthly - With or without her consent, when she is under sixteen years of age.

Explanation- Penetration is sufficient to constitute the sexual intercourse necessary to the offence of rape.

Exception- Sexual intercourse by a man with his own wife, the wife not being under fifteen years of age, is not rape.]

(2) Whoever,-

(a) being a police officer commits rape-

(i) within the limits of the police station to which he is appointed; or

(ii) in the premises of any station house whether or not situated in the police station to which he is appointed; or

(iii) on a woman in his custody or in the custody of a police officer subordinate to him; or

(b) being, a public servant, takes advantage of his official position and commits rape on a woman in his custody as such public servant or in the custody of a public servant subordinate to him; or

(c) being on the management or on the staff of a jail, remand home or other place of custody established by or under any law for the time being in force or of a woman's or children's institution takes advantage of his official position and commits rape on any inmate of such jail, remand home, place or institution; or

(d) being, on the management or on the staff of a hospital, takes advantage of his official position and commits rape on a woman in that hospital; or

(e) commits rape on a woman knowing her to be pregnant; or

(f) commits rape on a woman when she is under twelve years of age; or

(g) commits gang rape,

shall be punished with rigorous imprisonment for a term which shall not be less than ten years but which may be for life and shall also be liable to fine:

Provided that the court may, for adequate and special reasons to be mentioned in the judgment, impose a sentence of imprisonment of either description for a term of less than ten years.

S.376: Punishment for rape

(1) Whoever, except in the cases provided for by subsection (2), commits rape shall be punished with imprisonment of either description for a term which shall not be less than seven years but which may be for life or for a term which may extend to ten years and shall also be liable to fine unless the women raped is his own wife and is not under twelve years of age, in which cases, he shall be punished with imprisonment of either description for a term which may extend to two years or with fine or with both:

Provided that the court may, for adequate and special reasons to be mentioned in the judgement, impose a sentence of imprisonment for a term of less than seven years.

(2) Whoever,-

(a) being a police officer commits rape-

(i) within the limits of the police station to which he is appointed; or

(ii) in the premises of any station house whether or not situated in the police station to which he is appointed; or

(iii) on a woman in his custody or in the custody of a police officer subordinate to him; or

(b) being, a public servant, takes advantage of his official position and commits rape on a woman in his custody as such public servant or in the custody of a public servant subordinate to him; or

(c) being on the management or on the staff of a jail, remand home or other place of custody established by or under any law for the time being in force or of a woman's or children's institution takes advantage of his official position and commits rape on any inmate of such jail, remand home, place or institution; or

(d) being, on the management or on the staff of a hospital, takes advantage of his official position and commits rape on a woman in that hospital; or

(e) commits rape on a woman knowing her to be pregnant; or

(f) commits rape on a woman when she is under twelve years of age; or

(g) commits gang rape,

shall be punished with rigorous imprisonment for a term which shall not be less than ten years but which may be for life and shall also be liable to fine:

Provided that the court may, for adequate and special reasons to be mentioned in the judgement, impose a sentence of imprisonment of either description for a term of less than ten years.

Explanation 1- Where a woman is raped by one or more in a group of persons acting in furtherance of their common intention, each of the persons shall be deemed to have committed gang rape within the meaning of this sub-section.

Explanation 2- "Women's or children's institution" means an institution, whether called an orphanage or a home for neglected woman or children or a widows' home or by any other name,

which is established and maintained for the reception and care of woman or children.

Explanation 3- "Hospital" means the precincts of the hospital and includes the precincts of any institution for the reception and treatment of persons during convalescence or of persons requiring, medical attention or rehabilitation.

S.376D. Intercourse by any member of the management or staff of a hospital with any woman in that hospital

Whoever, being on the management of a hospital or hem. on the staff of a hospital takes advantage of his position and has sexual intercourse with any woman in that hospital, such sexual intercourse not amounting to the offence of rape, shall be punished with imprisonment of either description for a term which may extend to five years and shall also be liable to fine.

Explanation- The expression "hospital" shall have the same meaning as in Explanation 3 to sub-section (2) of section 376.]

III. Evidence in Torture Cases

Medical Evidence

The role of medical evidence is crucial to the proper investigation of torture or ill-treatment. While increasingly torture is carried out without leaving signs or with signs resolving within days leaving no permanent traces, experienced doctors can nevertheless evaluate testimony, accounts of post-trauma symptoms and physical and mental squeal and draw conclusions from these.

Indian Evidence Act, 1872

S.45. Opinions of experts

When the Court has to form and opinion upon a point of foreign law or of science or art, or as to identity of handwriting or finger impressions, the opinions upon that point of persons specially skilled in such foreign law, science or art, or in questions as to identity of handwriting or finger impressions are relevant facts.

Such persons are called experts. Illustrations

(a) The question is, whether the death of A was caused by poison.

The opinions of experts as to the symptoms produced by the poison by which A is supposed to have died, are relevant.

(b) The question is, whether A, at the time of doing a certain act, was, by reason of unsoundness of mind, incapable of knowing the nature of the Act, or that he was doing what was either wrong or contrary to law.

The opinions of experts upon the question whether the symptoms exhibited by A commonly show unsoundness of mind, and whether such unsoundness of mind usually renders persons incapable of knowing the nature of the acts which they do, or of knowing that what they do is either wrong or contrary to law, are relevant.

(c) The question is, whether a certain document was written by A. Another document is produced which is proved or admitted to have been written by A.

The opinions of experts on the question whether the two documents were written by the same person or by different persons are relevant.

S.46. Facts bearing upon opinions of experts

Facts, not otherwise relevant, are relevant if they support or are inconsistent with the opinions of experts, when such opinions are relevant illustrations

(a) The question is, whether A was poisoned by a certain poison.

The fact that other persons, who were poisoned by that poison, exhibited certain symptoms which experts affirm or deny to be symptoms of that poison is relevant.

(b) The question is, whether an obstruction to a harbour is caused by a certain sea-wall.

The fact that other harbours similarly situated in other respects, but where there were no such sea-walls, began to be obstructed at about the same time, are relevant.

B) The Supreme Court of India: Medico-legal Cases

1) Parmanand Katara v. Union of India, AIR 1989 SC 2039.

In this case, the Supreme Court considered a very serious problem existing at present: in a medico-legal case (such as an accident) the doctors usually refuse to g \ive immediate medical aid to the victim till legal formalities are completed. In some cases, the injured die for want of medical aid pending the completion of legal formalities.

The petitioner, who claims himself to be a human right activist, filed this writ petition in public interest on the basis of a newspaper report concerning the death of a scooterist who was knocked down by a speeding car. The report further states that the injured person was taken to the nearest hospital but the doctors there refused to attend on him; that they told that he be taken to another hospital, located some 20 kilometers away, which was authorised to handle medico-legal cases; and that the victim succumbed to his injuries before he could be taken to the other hospital. The petitioner has prayed the directions be issued to the Union of India that every injured citizen brought for treatment should instantaneously be given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death, and in the event of breach of such direction, apart from any action that may be taken for negligence, appropriate compensation should be admissible.

The Secretary, Ministry of Health & Family Welfare of the Union of India, the Medical Council of India, and the Indian Medical Association were later impleaded as respondents. Documents relating to the steps taken from time to time in this regard were produced by the respondents.

Reference was made to the Code of Medical Ethics drawn up by the Medical Council of India, wherein the need to attend to the injured/serious persons immediately without waiting for the police report or completion of police formalities was recognized and the Government of India was requested to take necessary and immediate steps to amend various provisions of law which come in the way of government doctors as well as other doctors in private hospitals or public hospitals in this regard. Clause 10 of the Code obligates a physician to treat a person in an emergency situation promptly with care and due diligence for the '*sake of humanity*' and confirming with '*the noble traditions of the profession*'. Clause 13 clearly prohibits any sort of negligence by the physician in such a case. The proceedings of the meeting held on 29.5.1986 in which the Director General of Health Services acted as Chairman were also referred to. This Committee had formulated some guidelines. On behalf of the Union of India it was stated that there was no provision in the Indian Penal Code, Criminal Procedure Code, or the Motor Vehicles Act, etc. which prevented doctors from promptly attending seriously injured persons and accident cases before the arrival of police.

Disposing of the Writ Petition, the Court held (Misra Rangnath J.):

(1) Article 21 of the Constitution casts the obligation on the State to preserve life.

(1) There can be no second opinion that preservation of human life is of paramount importance. That is so on account of the fact that once life is lost, the status *quo ante* cannot be restored as resurrection is beyond the capacity of man.

(2) The patient whether he be an innocent person or a criminal liable to punishment under the laws of the society, it is the obligation of those who are in charge of the health of the community to preserve life so that the innocent may be protected and the guilty may be punished. Social laws do not contemplate death by negligence to tantamount to legal punishment.

(4) Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life.

(5) No law or State action can intervene to avoid/delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statute or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way.

(6) The Court gave directions for giving adequate publicity to the decision in this case by the national media, the Doordarshan and the all India Radio, as well as through the High Courts and the Sessions Judges.

G.L. Oza, J. in the concurring judgment stated:

(1) The Code of Medical Ethics framed by the Medical Council was approved on 23rd October, 1970. This only reveals an unfortunate state of affairs where the decisions are taken at the highest level good intentioned and for public good but unfortunately do not reach the common man and it only remains a text good to read and attractive to quote.

(2) It is clear that there is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. There is also no doubt that the effort to save the person should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with the matter or who happens to notice such an incident or a situation.

(3) The members of the legal profession, our law courts and everyone concerned will also keep in mind that a man in the medical profession should not be unnecessarily harassed for purposes of interrogation or for any other formality and should not be dragged during investigations at the police station and it should be avoided as far as possible.

(4) Law courts will not summon a medical professional to give evidence unless the evidence is necessary and even if he is summoned, attempt should be made to see that the men in this profession are not made to wait and waste time unnecessarily.

2) Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, AIR 1996 SC 2426.

In this case, a mazdoor, who is a member of Paschim Banga Khet Mazdoor Samity, an organisation of agricultural labourers, fell from a running train and suffered serious head injuries and brain haemorrhage. He was sent from one government hospital to another owing to variety of reasons and finally he was admitted in a private hospital where he had to incur expenditure of Rs. 17,000/- on his treatment.

Feeling aggrieved by the indifferent and callous attitude on the part of the medical authorities at the various State run hospitals in Calcutta in providing treatment for the serious injuries sustained by the mazdoor, the petitioners have filed this writ petition.

The Constitution envisages the establishment of a welfare state at the federal level as well as at the state level. In a welfare state the primary duty of the Government is to secure the welfare to the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21. In the present case there was breach of the said right of the injured mazdoor guaranteed under Article 21 when he was denied treatment at the various Government hospitals which were approached even though his condition was very serious at that time and he was in need of immediate medical attention. Since the said denial of the right of mazdoor guaranteed under Article 21 was by officers of the State in hospitals run by the State the State cannot avoid its responsibility for such denial of the constitutional right of mazdoor. In respect of deprivation of the constitutional rights guaranteed under Part-III of the Constitution the position is well settled that adequate compensation can be awarded by the court for such violation by way of redress in proceedings under Articles 32 and 226 of the Constitution. Hence, the Court ordered compensation of Rs. 25,000/- to the injured mazdoor. Moreover, the Court issued several directions for avoidance of any such incidents in the future and to ensure immediate medical attention and treatment to persons in real need.

C) The Supreme Court Guidelines on Lawful Arrest

Torture of ordinary criminal suspects and political prisoners by police has long been widespread in India. Torture and ill-treatment are used to extract confessions, to extort money and to punish detainees. Methods of torture and ill-treatment include electric shocks, suspension from ceilings, severe beating with *lathis* (long wooden sticks) and kicking. Most torture occurs during periods of illegal detention following arrests that are unrecorded.

Torture persists despite official acknowledgment of the problem and a series of positive judicial and administrative initiatives in recent years.[1]

In September 1996 the Supreme Court of India made a landmark judgment condemning custodial violence and making several recommendations (see below). This allowed the development of practical mechanisms for preventing torture during arrest and detention and has had a significant impact on the manner in which individuals can be arrested and detained. Although levels of custodial violence have continued to be high, the judgment has forced police to rethink their widespread use of illegal detention and torture, and has provided human rights activists with a stronger legal position from which to challenge such practices. Crucially, the Supreme Court has treated custodial violence as an ongoing concern and continues to monitor implementation of its recommended safeguards and to issue further orders to protect detainees.

Background to the 1996 judgment

The origins of the 1996 judgment lie in the state of West Bengal 10 years earlier. On 26 August 1986 the Executive Chairman of the Legal Aid Services, D.K. Basu, wrote to the Chief Justice of the Supreme Court of India highlighting concerns about custodial violence in the state and reported deaths in custody.[2] He argued that it was vital to examine the issues, develop "custody jurisprudence", formulate steps for awarding compensation to the victims or their relatives, and ensure accountability of police officers found responsible for torture.

The Supreme Court accepted D.K. Basu's request that his letter be treated as a Public Interest Litigation and asked the respondents – the State of West Bengal – to reply to the charges made in the petition. The state government of West Bengal replied that the police were not covering up deaths in custody and that wherever police personnel were found to be responsible, action was being taken against them.

On 14 August 1987 the Supreme Court stated that there were increasing allegations of custodial violence in almost every state and a rising number of reported deaths in custody. The Court noted that there appeared to be no machinery to deal effectively with such allegations. It issued an order

---

[1] Torture is not explicitly prohibited by Indian law. India signed the Convention against Torture in 1997 but had not yet ratified it at the time of writing of this manual.

[2] D.K. Basu was, in the 1970s, an advocate practising in the West Bengal High Court, where he spent much of his time defending victims of torture. He founded the Legal Aid Services–West Bengal, a state-level social action group based in Calcutta.

requesting all state governments to provide their response to the allegations, and further requesting the Law Commission of India to make suitable suggestions in relation to the question of custodial violence.

In response to this order, affidavits were filed by several state governments, by the central government and by the Law Commission of India concerning custodial violence. The Court appointed a Supreme Court lawyer, Dr A.M. Singhvi, to act as *amicus curiae* (friend of the court) to help it gather information on custodial violence.

In 1992 D.K. Basu – by this time a judge with the West Bengal High Court – gave a comprehensive judgment in his court on the issue of custodial violence. He set out in full the processes he thought should be followed to prevent custodial violence, to ensure independent investigations leading to prosecution of those responsible, and to provide compensation for victims.

In the meantime, between 1986 and 1996, newspapers reported cases of torture and deaths in custody, human rights organizations raised such cases and pursued them in the courts, and Amnesty International conducted a major international campaign on human rights violations in India, putting forward detailed recommendations on arrest and custody procedures to combat torture and other abuses of human rights.

The 1996 judgment

In 1996 the Supreme Court finally issued its judgment in the case of *Basu v. State of* West Bengal.[3] The judgment expressed the Supreme Court's concern that "torture is more widespread now than ever before". It stated that "'[c]ustodial torture' is a naked violation of human dignity and degradation which destroys, to a very large extent, the individual personality. It is a calculated assault on human dignity and whenever human dignity is wounded, civilization takes a step backward."

The judgment referred to international human rights standards and to the fact that Article 21 of the Constitution of India protects the right to life, a provision that has been held by the Indian courts to include a guarantee against torture. It also made general recommendations relating to amendments to the law on burden of proof and the need for police training, and put forward arguments against the right to sovereign immunity for agents of the state responsible for torture and in favour of compensation.

The judgment's most far-reaching legacy is its 11 "requirements" to be followed in all cases of arrest and detention (para. 35). The "requirements" would, the Court hoped, "help to curb, if not totally eliminate, the use of questionable methods during interrogation and investigation" (para. 39). Briefly (and paraphrased), the requirements set out by the Supreme Court are as follows:

[3] AIR 1997 SC 610.

1. Police arresting and interrogating suspects should wear "accurate, visible and clear" identification and name tags, and details of interrogating police officers should be recorded in a register.[4]

2. Police making an arrest should prepare a memo of arrest to be signed by a witness and countersigned by the arrested person, giving the time and date of arrest.

3. Anyone arrested should be entitled to have a friend or relative informed of their arrest and place of detention "as soon as practicable".[5]

4. If such a friend or relative lives outside the district, the time and place of arrest and place of detention should be notified to them by police through the Legal Aid Organization within eight to 12 hours.

5. Anyone arrested should be informed of their right to inform someone of their arrest and detention "as soon as" they are arrested.

6. Information about the arrest and the details of the person informed of the arrest should be kept in a diary at the place of detention along with names of police officers supervising custody.[6]

7. On request, anyone arrested should be examined at the time of arrest and any injuries recorded. This "inspection memo" should be signed by the arrested person and the arresting police officer, and a copy given to the arrested person.[7]

8. Anyone arrested should be medically examined by a doctor every 48 hours during detention.[8]

9. Copies of all the documents referred to above should be sent to the magistrate.[9]

10. Anyone arrested should be permitted to meet their lawyer during interrogation "though not throughout the interrogation".

11. A police control room should be established at all district and state headquarters with information regarding details of those arrested and their place of custody displayed on a notice board.

---

[4] Plainclothes police officers have regularly arrested and interrogated people in India, making it difficult for victims to identify their torturers.

[5] This is an important safeguard against unacknowledged illegal detention, particularly crucial in areas of armed conflict in India where "disappearances" are common.

[6] The practice of keeping a "general diary" of arrests at police stations has fallen into disuse, so there are often no records that people have been detained. Lawyers or judicial authorities depend on these records if there are complaints of ill-treatment or other abuses during detention.

[7] Police in India have often claimed that detainees were injured before arrest or were unwell at the time of arrest and that their condition subsequently deteriorated, thereby arguing that deaths in custody were not the result of police violence.

[8] In issuing this requirement, the court was seeking to ensure evidence of the medical condition of detainees as a means of guarding against conflicting allegations of torture, etc.

[9] Under section 57 of the Code of Criminal Procedure, all detainees in India must be brought before a magistrate within 24 hours of arrest. The magistrate then decides whether to remand them to further police or judicial custody. By requiring that these initial custody records are forwarded to the magistrate at the time of the detainee's appearance before the magistrate, the Supreme Court was attempting to provide checks for the magistrate to ensure that proper legal procedures had been followed. Under normal circumstances the magistrate would only have the word of the detainee or their lawyer against that of the police if there were allegations of illegal detention.

Although the Supreme Court commented that these requirements should be followed until "legal provisions are made in that behalf" (para. 35), it was no doubt aware of previous judicial directions along similar lines which had still not led to amendments in law. The Court could not direct the government to enact legislation, but stated that in its opinion it was clearly desirable that existing legislation should be amended to incorporate the "requirements". This view was supported in November 2000 by the Law Commission of India, which in its Consultation Paper on Law Relating to Arrest recommended incorporation of the "requirements" into law. As of June 2002 the Indian government had not given any commitment that it intended to do so.

To reinforce the "requirements", the judgment stated that "Failure to comply with the requirements herein above-mentioned shall, apart from rendering the concerned official liable for departmental action, also render him liable to be punished for contempt of court and the proceedings for contempt of court may be instituted in any High Court of the country having territorial jurisdiction over the matter" (para. 36). The judgment further ordered that the requirements be issued to the Director Generals of Police and Home Secretaries of all states who in turn are obliged to circulate them to every police station under their jurisdiction and to have them posted in a conspicuous place in every police station. It also recommended that the requirements be broadcast on radio and television and distributed in pamphlets in local languages "creating awareness... transparency and accountability" (para. 39).

SOURCE: Largely borrowed from Amnesty International, Combating Torture: A Manual for Action with modifications.
Available at http://web.amnesty.org/library/Index/ENGACT400012003?open&of=ENG-ZAF

D) Supreme Court Guidelines on Sexual Harassment at Workplace

The Supreme Court's judgment in Visakha's case[1] is a landmark for more than one reason. Not only was sexual harassment at the work place recognized under the Indian jurisprudence as a crucial problem faced by women workers, it also set out detailed guidelines for prevention and redressal of this malaise. The judgment was delivered by J.S.Verma. CJ, on behalf of Sujata Manohar and B.N.Kirpal, JJ., on a writ petition filed by 'Vihska'- a non Governmental organization working for gender equality by way of PIL seeking enforcement of fundamental rights of working women under Article.21 of the Constitution. The immediate cause for filing the petition was the alleged brutal gang rape of a village-level social worker of Rajasthan who tried to stop a child marriage taking place in her village.

Gender equality includes protection from sexual harassment and right to work with dignity, which is a universally recognized basic human right. The common minimum requirement of this right has received global acceptance. The International Conventions and norms are, therefore, of great significance in the formulation of the guidelines to achieve this purpose.

In view of this and the absence of enacted law to provide for the effective enforcement of the basic human right of gender equality and guarantee against sexual harassment and abuse, more particularly against sexual harassment at work places, the Supreme Court in this case incorporated various provisions of 'Convention on the Elimination of All Forms of Discrimination against Women' into the Indian law laying down the guidelines and norms specified hereinafter for due observance at all work places or other institutions, until a legislation is enacted for the purpose. This was done in exercise of the power available under Article 32 of the Constitution for enforcement of the fundamental rights and it is further emphasised that this would be treated as the law declared by this Court under Article 141 of the Constitution.

The guidelines and norms pre-scribed herein are as under:

Having regard to the definition of 'human rights' in Section 2(d) of the Protection of Human Rights Act, 1993.

Taking note of the fact that the present civil and penal laws in India do not adequately provide for specific protection of women from sexual harassment in work places and that enactment of such legislation will take considerable time.

It is necessary and expedient for employers in work places as well as other responsible persons or institutions to observe certain guidelines to ensure the prevention of sexual harassment of women:

---

[1] **Vishaka and others v. State of Rajasthan and Others, AIR 1997 SC 3011.**

1. Duty of the Employer or other responsible persons in work places and other institutions:

It shall be the duty of the employer or other responsible persons in work places or other institutions to prevent or deter the commission of acts of sexual harassment and to provide the procedures for the resolution, settlement or prosecution of acts of sexual harassment by taking all steps required.

2. Definition:

For this purpose, sexual harassment includes such unwelcome sexually determined behaviour (whether directly or by implication) as:

a) physical contact and advances;

b) a demand or request for sexual favours;

c) sexually coloured remarks;

d) showing pornography;

e) any other unwelcome physical, verbal or non-verbal conduct of sexual nature.

Where any of these acts is committed in circumstances whereunder the victim of such conduct has a reasonable apprehension that in relation to the victim's employment or work whether she is drawing salary, or honorarium or voluntary, whether in Government, public or private enterprise such conduct can be humiliating and may constitute a health and safety problem. It is discriminatory for instance when the woman has reasonable grounds to believe that her objection would disadvantage her in connection with her employment or work including recruiting or promotion or when it creates a hostile work environment. Adverse consequences might be visited if the victim does not consent to the conduct in question or raises any objection thereto.

3. Preventive Steps:

All employers or persons in charge of work place whether in the public or private sector should take appropriate steps to prevent sexual harassment. Without prejudice to the generality of this obligation they should take the following steps:

a. Express prohibition of sexual harassment as defined above at the work place should be notified, published and circulated in appropriate ways.

b. The Rules/Regulations of Government and Public Sector bodies relating to conduct and discipline should include rules/regulations prohibiting sexual harassment and provide for appropriate penalties in such rules against the offender.

c. As regards private employers steps should be taken to include the aforesaid prohibitions in the. standing orders under the Industrial Employment (Standing Orders) Act, 1946.

d. Appropriate work conditions should be provided in respect of work, leisure, health and hygiene to further ensure that there is no hostile environment towards women at work

places and no employee woman should have reasonable grounds to believe that she is disadvantaged in connection with her employment.

4. Criminal Proceedings:

Where such conduct amounts to a specific offence under the Indian Penal Code or under any other law, the employer shall initiate appropriate action in accordance with law by making a complaint with the appropriate authority.

In particular, it should ensure that victims, or witnesses are not victimized or discriminated against while dealing with complaints of sexual harassment. The victims of sexual harassment should have the option to seek transfer of the perpetrator or their own transfer.

5. Disciplinary Action:

Where such conduct amounts to misconduct in employment as defined by the relevant service rules, appropriate disciplinary action should be initiated by the employer in accordance with those rules.

6. Complaint Mechanism:

Whether or not such conduct constitutes an offence under law or a breach of the service rules, an appropriate complaint mechanism should be created in the employer's organization for redress of the complaint made by the victim. Such complaint mechanism should ensure time bound treatment of complaints.

7. Complaints Committee:

The complaint mechanism, referred to in (6) above, should be adequate to provide, where necessary, a Complaints Committee, a special counselor or other support service, including the maintenance of confidentiality.

The Complaints Committee should be headed by a woman and not less than half of its member should be women. Further, to prevent the possibility of any undue pressure or influence from senior levels, such Complaints Committee should involve a third party, either NGO or other body who is familiar with the issue of sexual harassment.

The Complaints Committee must make an annual report to the Government department concerned of the complaints and action taken by them.

The employers and person in charge will also report on the compliance with the aforesaid guidelines including on the reports of the Complaints Committee to the Government department.

8. Workers' Initiative:

Employees should be allowed to raise issues of sexual harassment at workers' meeting and in other appropriate forum and it should be affirmatively discussed in Employer-Employee Meetings.

9. Awareness:

Awareness of the rights of female employees in this regard should be created in particular by prominently notifying the guidelines (and appropriate legislation when enacted on the subject) in a suitable manner.

10. Third Party Harassment:

Where sexual harassment occurs as a result of an act or omission by any third party or outsider, the employer and person in charge will take all steps necessary and reasonable to assist the affected person in terms of support and preventive action.

11. The Central/State Governments are requested to consider adopting suitable measures including legislation to ensure that the guidelines laid down by this order are also observed by the employers in Private Sector.

12. These guidelines will not prejudice any rights available under the Protection of Human Rights Act, 1993.

The court ordered directed that:

> "....the above guidelines and norms would be **strictly observed** in all work places for the preservation and enforcement of the right to gender equality of the working women. These directions would be binding and enforceable in law until suitable legislation is enacted to occupy the field."

E) National Human Rights Institutions

Introduction:

Apart from the formal justice delivery system in the country, there also exists a number of statutory as well as constitutional institutions, which are referred to as National Human Rights Institutions (NHRIs) which are entrusted with a complaint-mechanism system in case of human rights violations, overseeing the status of human rights and work for its improvement in the country. These institutions can always become important alternative avenues in the fight against the torture. They are introduced briefly in the following pages.

1.1 The National Human Rights Commission

The National Human Rights Commission is an expression of India's concern for the protection and promotion of human rights. It came into being in October, 1993. The Protection of Human Rights Act 1993 (PHRA) provides for the establishment of a National Human Rights Commission, State Human Rights Commission in States and Human Rights Courts for better protection of Human Rights and for matters connected therewith or incidental thereto.

The National as well as the State Commissions consist of a Chairperson and four members.

Website: http://www.nhrc.nic.in

i) The purpose of the PHRA :

The Parliament of India enacted the PHRA in 1993 for the following purposes:

1. To provide for the constitution of a National Human Rights Commission;
2. To provide for the constitution of a State Human Rights Commission in States; and
3. To provide for the constitution of Human Rights Courts for better protection of Human Rights and for matters connected therewith.

This Act came into force on 28th September 1993.

ii) Definition of Human Rights:

According to Section 2 (d) of the Protection of Human Rights Act, "Human Rights" means the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the international covenants and enforceable by courts in India.

iii) The National Human Rights Commission:

The National Human Rights Commission shall be constituted by the Central Government. It shall consist of:

1. A Chairperson, who has been a Chief Justice of the Supreme Court;
2. One Member who is, or has been, a Judge of the Supreme Court;

3. One Member who is, or has been, the Chief Justice of a High Court;
4. Two Members to be appointed from amongst persons having knowledge of, or practical experience in, matters relating to human rights.

iv) Deemed Members of the Commission

The following persons shall be deemed to be members of the commission for discharging the functions specified in clauses (b) to (j) of Section 12:

a. The Chairperson of the National Commission for minorities
b. The National Commission for the Scheduled Castes and Scheduled Tribes
c. The National Commission for the Women

v) Headquarters of NHRC

The headquarters of the National Human Rights Commission shall be at Delhi. If necessary, offices may be established at other places of India with the approval of the Central Government.

vi) Functions of the National Human Rights Commission

The following are the functions to be performed by the National Human Rights Commission as per Section 12 of the Act:

1. Inquire, *suo motu* or on a petition presented to it by a victim or any person on his behalf, into complaint of:
   a. Violation of human rights or abetment thereof or
   b. Negligence in the prevention of such violation, by a public servant.
2. Intervene in any proceeding involving any allegation of violation of human rights pending before a court with the approval of such court;
3. Visit, under intimation to the State Government, any jail or any other institution under the control of the State Government, where persons are detained or lodged for purposes of treatment, reformation or protection to study the living conditions of the inmates and make recommendations thereon;
4. Review the safeguards provided by or under the Constitution or any law for the time being in force for the protection of human rights and recommend measures for their effective implementation;
5. Review the factors, including acts of terrorism that inhibit the enjoyment of human rights and recommend appropriate remedial measures;
6. Study treaties and other international instruments on human rights and make recommendations for their effective implementation;
7. Undertake and promote research in the field of human rights;

8. Spread human rights literacy among various sections of society and promote awareness of the safeguards available for the protection of these rights through publications, the media, seminars and other available means;

9. Encourage the efforts of non-governmental organizations and institutions working in the field of human rights;

10. Such other functions as it may consider necessary for the promotion of human rights.

vii) Procedure for dealing with complaints

The procedure for dealing with the complaints by the National Human Rights Commission is prescribed in paragraph 8 of the NHRC (Procedure) Regulations, 1994. It states that:

1. All complaints in whatever form received by the Commission shall be registered and assigned a number and placed for admission before a bench of two Members constituted for the purpose not later than two weeks of receipt thereof. Ordinarily complaints of the following nature are NOT entertained by the Commission:

    a. In regard to events which happened more than one year before the making of the complaints;

    b. With regard to matters which are sub-judice;

    c. Which are vague, anonymous or pseudonymous;

    d. Which are of frivolous nature, or

    e. Those, which are outside the purview of the Commission.

2. No fee is chargeable on complaints.

3. Every attempt should be made to disclose a complete picture of the matter leading to the complaint and the same may be made in English or Hindi to enable the Commission to take immediate action. To facilitate the filing of the complaints, the Commission shall, however, entertain complaints in any language included in Eighth Schedule of the Constitution. It shall be open to the Commission to ask for further information and affidavits to be filed in support of allegations whenever considered necessary.

4. The Commission may, in its discretion, accept telegraphic complaints and complaints conveyed through Fax.

5. The Commission shall have power to dismiss a compliant in limini.

6. Upon admission of a complaint, the Chairperson/Commission shall direct whether the matter would be set down for inquiry by it or should be investigated into.

7. On every complaint on which the Chairperson/Commission takes a decision to either hold an inquiry or investigation, the Secretariat shall call for reports/comments from the concerned Government/authority giving the latter a reasonable time therefor.

8. On receipt of the comments of the concerned authority, a detailed note on the merits of the case shall be prepared for consideration of the Commission.

9. The directions and recommendations of the Commission shall be communicated to the concerned Government/authority and the petitioner as provided for in sections 18 and 19 of the Act within one week of completion of the proceedings before the Commission. On receipt of the comments of the concerned Government or authority, the Commission shall publish the report within one week of the receipt of the appropriate intimation.

10. The Commission may, in its discretion, afford a personal hearing to the petitioner or any other person on his behalf and such other person or persons as in the opinion of the Commission should be heard for appropriate disposal of the matter before it and, where necessary, call for records and examine witnesses in connection with it. The Commission shall afford a reasonable hearing, including opportunity of cross-examining witnesses, if any, in support of the complaint and leading of evidence in support of his stand, to a person whose conduct is enquired in to be it or where in its opinion the reputation of such person is likely to be prejudicially affected.

11. Where investigation is undertaken by the team of the Commission (The Commission shall have its own team of investigation to be headed by a person not below the rank of a Director General of Police, 2 Superintendents of Police, 6 Deputy Superintendents of Police and 24 inspectors of Police and such other categories of officers as the Commission from time to time decides. The Commission may in any given case appoint an appropriate number of outsiders to be associated with the investigation either as Investigators or Observers) or by any other person under its discretion, the report shall be submitted within a week of the completion or such further time as the Commission may allow. The Commission may, in its discretion, direct further investigation in a given case if it is of opinion that investigation has not been proper or the matter requires further investigation for ascertaining the truth or enabling it to properly dispose of the matter. On receipt of the report, the Commission on its own motion, or if moved in the matter, may direct inquiry to be carried by it and receive evidence in course of such inquiry.

12. The Commission or any of its Members when requested by the Chairperson may undertake visits for an on-the-spot study and where such study is undertaken by one or more members, a report thereon shall be furnished to the Commission as early as possible.

viii) Powers of NHRC relating to inquiries

Every proceeding before NHRC shall be deemed to be a judicial proceeding and the Commission shall be deemed to be a Civil Court. While inquiring in to complaints under the Act, the NHRC shall have all the powers of a Civil Court trying a suit under the Code of Civil Procedure, and in particular NHRC shall have the following powers:

- Summoning and enforcing the attendance of witnesses and examining them on oath;
- Discovery and production of any document;
- Receiving evidence on affidavits;
- Requisitioning any public record or copy thereof from any Court or office;
- Issuing commissions for the examination of witnesses or documents;

ix) Investigation by NHRC

The NHRC shall have its own team of investigation to be headed by a person not below the rank of a Director General of Police, 2 Superintendents of Police, 6 Deputy Superintendents of Police and 24 inspectors of Police and such other categories of officers as the Commission from time to time decides. The NHRC may in any given case appoint an appropriate number of outsiders to be associated with the investigation either as Investigators or Observers.

x) Steps to be taken by NHRC after inquiry

After completion of the inquiry the NHRC may take any of the following steps:

1. Where the inquiry discloses the commission of violation of human rights or negligence in the prevention of violation of human rights by a public servant, it may recommend to the concerned Government or authority the initiation of proceedings for prosecution or such other action as the commission may deem fit against the concerned person or persons;
2. Approach the Supreme court or the concerned High court for such directions, orders or writs as the Court may deem necessary;
3. Recommend to a concern Government or authority for the grant of such immediate interim relief to the victim or the members of its family as the commission may consider necessary;
4. Provide copy of the inquiry report to the petitioner or his representative;
5. Send a copy of the inquiry report together with recommendations to the concerned Government or authority and the concerned Government or authority shall, within a period of one month, or such further time as the NHRC may allow, forward to NHRC, its comments on the report, including the action taken or proposed to be taken;
6. Publish its inquiry report together with the comments of the concerned Government or authority, if any, and the action taken or proposed to be taken by the concerned Government or authority on the recommendations of the commission;

xii) State Human Rights Commission

The respective State Governments may constitute a body to be known as the (Name of the State) Human Rights Commission. The State Human Rights Commission shall consist of:

1. A Chairperson, who has been a Chief Justice of a High Court;
2. One Member who is, or has been, a Judge of a High Court;
3. One Member who is, or has been, a District Judge in that State;
4. Two Members to be appointed from amongst persons having knowledge of, or practical experience in, matters relating to human rights.

The Headquarters of the State Commission shall be at such place as the State Government may, by notification, specify.

The State Human Rights Commission may inquire into violation of Human Rights only in respect of matters relatable to any of the entries enumerated in List II and List III in the Seventh Schedule to the Constitution. If any matter is already being inquired into by the NHRC or any other Commission duly constituted under any law then the SHRC shall not inquire into the said matter.

The State Government shall make available to the Commission, an officer not below the rank of a Secretary to the State Government, who shall be the Secretary of the State Commission; and such police and investigative staff under an officer not below the rank of an Inspector General of Police and such other officers and staff as may be necessary for the efficient performance of the functions of the State Human Rights Commission.

The State Human Rights Commission is conferred with the power to regulate its own procedure.

xiii) Functions and Powers of the SHRC

The functions of the State Human Rights Commission are same as that of the National Human Rights Commission. The SHRC shall perform all of any of the following functions:

1. Inquire, *suo motu* or on a petition presented to it by a victim or any person on his behalf, into complaint of:
    a. Violation of human rights or abetment thereof or
    b. Negligence in the prevention of such violation, by a public servant.
2. Intervene in any proceeding involving any allegation of violation of human rights pending before a court with the approval of such court;
3. Visit, under intimation to the State Government, any jail or any other institution under the control of the State Government, where persons are detained or lodged for purposes of treatment, reformation or protection to study the living conditions of the inmates and make recommendations thereon;
4. Review the safeguards provided by or under the Constitution or any law for the time being in force for the protection of human rights and recommend measures for their effective implementation;
5. Review the factors, including acts of terrorism that inhibit the enjoyment of human rights and recommend appropriate remedial measures;
6. Undertake and promote research in the field of human rights;
7. Spread human rights literacy among various sections of society and promote awareness of the safeguards available for the protection of these rights through publications, the media, seminars and other available means;

8. Encourage the efforts of non-governmental organizations and institutions working in the field of human rights;

9. Such other functions as it may consider necessary for the promotion of human rights.

xiv) Powers of SHRC relating to inquiries

Every proceeding before SHRC shall be deemed to be a judicial proceeding and the Commission shall be deemed to be a Civil Court. While inquiring in to complaints under the Act, the SHRC shall have all the powers of a Civil Court trying a suit under the Code of Civil Procedure, and in particular SHRC shall have the following powers:

- Summoning and enforcing the attendance of witnesses and examining them on oath;
- Discovery and production of any document;
- Receiving evidence on affidavits;
- Requisitioning any public record or copy thereof from any Court or office;
- Issuing commissions for the examination of witnesses or documents;

xv) Investigation by SHRC

The SHRC may for the purpose of conducting any investigation pertaining to the inquiry, utilize the services of any officer or any investigation agency of the Central Government or any State Government with the concurrence of the Central Government or the State Government, as the case may be. The investigating officer shall investigate into any matter pertaining to the inquiry and submit a report to the SHRC within the period specified by SHRC.

For the purpose of investigation into any matter pertaining to the inquiry, the investigating officer or agency may summon and enforce the attendance of any person and examine him, require the discovery and production of any document, and requisition any public record or copy thereof from any office.

The SHRC shall satisfy itself about the correctness of the facts stated and the conclusion arrived at in the report submitted to it by making such inquiry including examination of the person or persons who conducted or assisted in the investigation.

No statement made by a person in the course of giving evidence shall be used against him in any civil or criminal proceeding except in prosecution for giving false evidence.

xvi) Steps to be taken by SHRC after inquiry

After completion of the inquiry the SHRC may take any of the following steps:

1. Where the inquiry discloses the commission of violation of human rights or negligence in the prevention of violation of human rights by a public servant, it may recommend to the concerned Government or authority the initiation of proceedings for prosecution or such other action as the commission may deem fit against the concerned person or persons;

2. Approach the Supreme court or the concerned High court for such directions, orders or writs as the Court may deem necessary;

3. Recommend to a concern Government or authority for the grant of such immediate interim relief to the victim or the members of its family as the commission may consider necessary;

4. Provide copy of the inquiry report to the petitioner or his representative;

5. Send a copy of the inquiry report together with recommendations to the concerned Government or authority and the concerned Government or authority shall, within a period of one month, or such further time as the NHRC may allow, forward to NHRC, its comments on the report, including the action taken or proposed to be taken;

6. Publish its inquiry report together with the comments of the concerned Government or authority, if any, and the action taken or proposed to be taken by the concerned Government or authority on the recommendations of the commission;

xvii) Human Rights Courts

The State Government may, with the concurrence of the Chief Justice of the High Court, by notification, specify for each district, a Court of Sessions to be a Human Rights Court for the purpose of providing speedy trial of "offences arising out of violation of human rights." The State Government shall specify a Public Prosecutor or appoint an advocate who has been in practice as an advocate for not less than 7 years, as a Special Public Prosecutor for every Human Rights Court, for the purpose of conducting cases in the Human Rights Courts.

1.2 National Commission for Women

The National Commission for Women was set up as statutory body in January 1992 under the National Commission for Women Act, 1990 (Act No. 20 of 1990 of Govt.of India) to :

- review the Constitutional and Legal safeguards for women ;
- recommend remedial legislative measures ;
- facilitate redressal of grievances and
- advise the Government on all policy matters affecting women.

In keeping with its mandate, the Commission initiated various steps to improve the status of women and worked for their economic empowerment during the year under report. The Commission completed its visits to all the States/UTs except Lakshdweep and prepared Gender Profiles to assess the status of women and their empowerment. It received a large number of complaints and acted suo-moto in several cases to provide speedy justice. It took up the issue of child marriage, sponsored legal awareness programmes, Parivarik Mahila Lok Adalats and reviewed laws such as Dowry Prohibition Act, 1961, PNDT Act 1994, Indian Penal Code 1860 and the National Commission for Women Act, 1990 to make them more stringent and effective. It organized workshops/consultations, constituted expert committees on economic empowerment of women, conducted workshops/seminars for

gender awareness and took up publicity campaign against female foeticide, violence against women, etc. in order to generate awareness in the society against these social evils.

The Commission consists of a Chairperson and five members. At least one member each shall be from amongst persons belonging to Scheduled Caste and Scheduled Tribe respectively.

Website: http://ncw.nic.in/

1.3 National Commission for Minorities

The Government of India constituted a National Commission for Minorities in May, 1993. The setting up of Minorities Commission was envisaged in the Ministry of Home Affairs Resolution dated 12.01.1978, which specifically mentioned that "despite the safeguards provided in the Constitution and the laws in force, there persists among the Minorities a feeling of inequality and discrimination. In order to preserve secular traditions and to promote National Integration the Government of India attaches the highest importance to the enforcement of the safeguards provided for the Minorities and is of the firm view that effective institutional arrangements are urgently required for the enforcement and implementation of all the safeguards provided for the Minorities in the Constitution, in the Central and State Laws and in the government policies and administrative schemes enunciated from time to time." The Commission was charged with the function of evaluating the various safeguards provided in the Constitution for the protection of the minorities and in the laws passed by the Parliament and the State legislatures. In course of time, the Commission suggested that its position be strengthened by conferring on it statutory powers of enquiry under the Commissions of Inquiry Act 1952. The Commission also suggested that it be given a constitutional status so that it could function more effectively. Accordingly, the Parliament enacted the Commission for Minorities Act, 1992 to establish the National Commission for Minorities on a statutory basis.

An interesting feature of the Act is that it does not define the term 'Minority' but leaves it to the Central Government to notify minorities for the purpose of the Act.

Website: http://www.ncm.nic.in

1.4 National Commission for Scheduled Castes

With a view to provide safeguards against the exploitation of Scheduled castes and Scheduled Tribes and to promote and protect their social, educational, economic and cultural interests, special provisions were made in the Constitution. Due to their social disability and economic backwardness, they were grossly handicapped in getting reasonable share in elected offices, Government jobs and educational institutions and, therefore, it was considered necessary to follow a policy of reservations in their favour to ensure their equitable participation in governance. Consequently, the National Commission for Scheduled Castes and Scheduled Tribes came into being on passing of the Constitution (Sixty fifth Amendment) Bill, 1990 which was notified on 8-6-1990. However, with the Constitution (Eighty-Ninth Amendment) Act, 2003 coming into force on 19-2-2004 vide

Notification of that date, the National Commission for Scheduled Castes & Scheduled Tribes got bifurcated and a separate National Commission for Scheduled Caste was constituted.

The Commission comprises of a Chairperson, a Vice-Chairperson and three other Members.

Website: http://ncsc.nic.in/

1.5 National Commission for Scheduled Tribes

Consequent upon the Constitution (Eighty-Ninth Amendment) Act, 2003 coming into force on 19-2-2004 vide Notification of that date, the National Commission for Scheduled Tribes was set up under Article 338A on the bifurcation of the erstwhile National Commission for Scheduled Castes and Scheduled Tribes to oversee the implementation of various safeguards provided to Scheduled Tribes under the Constitution. The Commission comprises a Chairperson, a Vice-Chairperson and three full time Members (including one lady Member). The term of all the Members of the Commission is three years from the date of assumption of charge. The National Commission for Scheduled Tribes functions from its Headquarters at New Delhi and from the State Offices of the Commission located in six States. The six State Offices of the National Commission for Scheduled Tribes which work closely with the Commission. They keep a watch on the formulation of policy and issue of guidelines relating to the welfare of Scheduled Tribes in the States and Union Territories and keep the Commission's Headquarters informed about the development periodically. Policy decisions taken by any State Government/UT Administration affecting the interests of the Scheduled Tribes are brought to the notice of the concerned authorities for necessary action.

To investigate and monitor all matters relating to the safeguards provided for the Scheduled Tribes, to inquire into specific complaints with respect to the deprivation of rights and safeguards of the Scheduled Tribes, to participate and advise in the planning process of socio-economic development of the STs, to make necessary recommendations for their protection, welfare and socio-economic development are some of the duties and functions assigned to the Commission.

F) Selected Guidelines of the NHRC

1. Letter to chief ministers of states on the video filming of post-mortem examinations in cases of custodial deaths.

Justice Ranganath Misra August 10,1995

Chairperson

My dear Chief Minister,

The National Human Rights Commission soon after its constitution in October, 1993, called upon the law and order agencies at the district level throughout the country to report matters relating to custodial death and custodial rape within 24 hours of occurrence. Since then ordinarily reports of such incidents have been coming to the Commission through the official district agencies. The Commission is deeply disturbed over the rising incidents of death in police lock-up and jails. Scrutiny of the reports in respect of all these custodial deaths by the Commission very often shows that the post-mortem in many cases has not been done properly. Usually the reports are drawn up casually and do not at all help in the forming of an opinion as to the cause of death. The Commission has formed an impression that a systematic attempt is being made to suppress the truth and the report is merely the police version of the incident.

The post-mortem report was intended to be the most valuable record and considerable importance was being placed on this document in drawing conclusions about the death.

The Commission is of a prima-facie view that the local doctor succumbs to police pressure which leads to distortion of the facts. The Commission would like that all post-mortem examinations done in respect of deaths in police custody and in jails should be video-filmed and cassettes be sent to the Commission along with the post-mortem report. The Commission is alive to the fact that the process of video-filming will involve extra cost but you would agree that human life is more valuable than the cost of video-filming and such occasions should be very limited.

We would be happy if you would be good enough to immediately sensitise the higher officials in your state police to introduce video-filming of post mortem examination with effect from 1st October, 1995.

We look forward for your response within three weeks.

With regards,

Yours sincerely,

Sd/-

To

(Ranganath Misra)

Chief Ministers of all States, Pondicherry & the National Capital Territory of Delhi / Governors of those States under the President's rule.

2. Letter to chief ministers/administrators of all states/union territories with a request to adopt the model autopsy form and the additional procedure for inquest.

Justice M.N. Venkatachaliah
Chairperson
(Former Chief Justice of India)

No. NHRC/ID/PM/96/57
National Human Rights Commission

March 27, 1997

Dear Chief Minister,

May I invite your kind attention to a matter which NHRC considers of some moment in its steps to deal with custodial deaths? The Commission on the 14th December, 1993 had issued a general circular requiring all the District Magistrates and the Superintendents of Police to report to the Commission, incidents relating to custodial deaths and rapes within 24 hours of their occurrence. A number of instances have come to the Commission's notice where the post-mortem reports appear to be doctored due to influence/pressure to protect the interest of the police/jail officials. In some cases it was found that the post-mortem examination was not carried out properly and in others, inordinate delays in their writing or collecting. As there is hardly any outside independent evidence in cases of custodial violence, the fate of the cases would depend entirely on the observations recorded and the opinion given by the doctor in the post-mortem report. If post-mortem examination is not thoroughly done or manipulated to suit vested interests, then the offender cannot be brought to book and this would result in travesty of justice and serious violation of human rights in custody would go on with impunity.

With a view to preventing such frauds, the Commission recommended to all the States to video-film the post-mortem examination and send the cassettes to the Commission.

It was felt that the Autopsy Report forms now in use in the various States, are not comprehensive and, therefore, do not serve the purpose and also give scope for doubt and manipulation. The Commission, therefore, decided to revise the autopsy-form to plug the loopholes and to make it more incisive and purposeful.

The Commission, after ascertaining the views of the States and discussing with the experts in the field and taking into consideration, though not entirely adopting, the U.N. Model Autopsy protocol, has prepared a Model Autopsy form enclosed as Annexure-I.[1]

In this connection, it was felt that some incidental improvements are also called for in regard to the conduct of inquests. For proper assessment of "Time since death" or 'the time of

[1] Available at http://www.nhrc.nic.in (Pathway for the search: Homepage – Important Instructions – Custodial deaths/Rape).

death', determination of temperature changes and development of Rigor Mortis at the time of first examination at the scene is essential. This can conveniently be done by following some easily understandable and implementable procedure. The procedure to be followed by those in charge of inquest, is indicated in Annexure-II[2] to this letter. This is a small but important addition to the inquest procedure.

The Commission recommends your Government to prescribe the Model Autopsy Form (Annexure-I) and the additional procedure for inquest as indicated in Annexure-II, to be followed in your State with immediate effect.

I shall look forward to your kind and favourable response.

Yours sincerely,

Sd/-

(M.N. Venkatachaliah)

To

Chief Ministers of all States/Union Territories.

[2] Available at http://www.nhrc.nic.in (Pathway for the search: Homepage – Important Instructions – Custodial deaths/Rape).

3. Guidelines relating to administration of polygraph test

[Lie Detector Test]

No. 117/8/97-98
National Human Rights Commission
(Law Division-III)

S. K. Srivastava
Assistant Registrar (Law)

Sardar Patel Bhavan,
Sansad Marg,
New Delhi -110 001.

11, January, 2000

To

Chief Secretaries of States /Union Territories.

Sub: Guidelines Relating to Administration of Polygraph Test (Lie Detector Test).

Sir,

I am directed to state that the Commission in its proceeding on 12.11.1999 has considered the Guidelines relating to Administration of Polygraph Test (Lie Detector Test) on an accused and directed that:

"The Commission adopted the Guidelines and decided that it should be circulated to all concerned authorities for being followed scrupulously."

Accordingly, a copy of the above Guidelines is forwarded herewith.

You are, therefore, requested to follow the said guidelines and acknowledge the same.

Yours faithfully,

Sd/-Assistant

Registrar (Law)

Encl: As above.

3 (a) Guidelines Relating to Administration of Polygraph Test (Lie Detector Test) on an Accused

The Commission has received complaints pertaining to the conduct of Polygraph Test (Lie Detector Test) said to be administered under coercion and without informed consent. The tests were conducted after the accused was allegedly administered a certain drug. As the existing police practice in invoking Lie Detector Test is not regulated by any 'Law' or subjected to any guidelines, it could tend to become an instrument to compel the accused to be a witness against himself violating the constitutional immunity from testimonial compulsion.

These matters concerning invasion of privacy have received anxious consideration from the Courts (see Gomathi Vs. Vijayaraghavan (1995) Cr. L.J. 81 (Mad); Tushaar Roy Vs. Sukla Roy (1993) Cr. L.J. 1959 (Cal); Sadashiv Vs. Nandini (1995) Cr. L.J. 4090). A suggestion for legislative intervention was also made, in so far as matrimonial disputes were concerned. American Courts have taken the view that such tests are routinely a part of everyday life and upheld their consistence with due process (See Breithbaupht Vs. Abram (1957) 352 US 432). To hold that because the privilege against testimonial compulsion "protects only against extracting from the person's own lips" (See Blackford Vs. US (1958) 247 F (20) 745), the life and liberty provisions are not attracted may not be wholly satisfactory. In India's context the immunity from invasive-ness (as aspect of Art. 21) and from self-incrimination (Art. 20 (3)) must be read together. The general executive power cannot intrude on either constitutional rights and liberty or, for that matter any rights of a person (See Ram Jawayya Kapur (1955) 2 SCR 225). In the absence of a specific 'law', any intrusion into fundamental rights must be struck down as constitutionally invidious (See Ram Jawayya Kapur (1955) 2 SCR 225; Kharak Singh (1964) 1 SCR 332 at pp. 350; Bennett Coleman (1972) 2 SCR 288 at pr. 26-7; Thakur Bharat Singh (1967) 2 SCR 454 at pp. 459-62; Bishamber Dayal (1982) 1 SCC 39 at pr. 20-27; Naraindass (1974) 3 SCR at pp. 636-8; Satwant (1967) 3 SCR 525). The lie detector test is much too invasive to admit of the argument that the authority for Lie Detector Tests comes from the General power to interrogate and answer questions or make statements (Ss 160-167 Cr. P.C.). However, in India we must proceed on the assumption of constitutional invasiveness and evidentiary impermissiveness to take the view that such holding of tests is a prerogative of the individual not an empowerment of the police. In as much as this invasive test is not authorised by law, it must perforce be regarded as illegal and unconstitutional unless it is voluntarily undertaken under non-coercive circumstances. If the police action of conducting a lie detector test is not authorised by law and impermissible, the only basis on which it could be justified is, it is volunteered. There is a distinction between: (a) volunteering, and (b) being asked to volunteer. This distinction is of some significance in the light of the statutory and constitutional protections available to any person. There is a vast difference between a person saying, "I wish to take a lie detector test because I wish to clear my name", and a person is told by the police, "If you want to clear your name, take a lie detector test". A still worse situation would be where the police say, "Take a lie detector test, and we will let you go". In the first example, the person voluntarily

wants to take the test. It would still have to be examined whether such volunteering was under coercive circumstances or not. In the second and third examples, the police implicitly (in the second example) and explicitly (in the third example) link up the taking of the lie detector test to allowing the accused to go free.

The extent and nature of the 'self-incrimination' is wide enough to cover the kinds of statements that were sought to be induced. In M.P. Sharma AIR 1954 SC 300, the Supreme Court included within the protection of the self-incrimination rule all positive volitional acts which furnish evidence. This by itself would have made all or any interrogation impossible. The test - as stated in Kathi Kalu Oghad (AIR 1961 SC 1808)-retains the requirement of personal volition and states that 'self-incrimination' must mean conveying information based upon the personal knowledge of the person giving information'. By either test, the information sought to be elicited in a Lie Detector Test is information in the personal knowledge of the accused.

The Commission, after bestowing its careful consideration on this matter of great importance, lays down the following guidelines relating to the administration of Lie Detector Tests:

i. No Lie Detector Tests should be administered except on the basis of consent of the accused. An option should be given to the accused whether he wishes to avail such test.

ii. If the accused volunteers for a Lie Detector Test, he should be given access to a lawyer and the physical, emotional and legal implication of such a test should be explained to him by the police and his lawyer.

iii. The consent should be recorded before a Judicial Magistrate.

iv. During the hearing before the Magistrate, the person alleged to have agreed should be duly represented by a lawyer.

v. At the hearing, the person in question should also be told in clear terms that the statement that is made shall not be a 'confessional' statement to the Magistrate but will have the status of a statement made to the police.

vi. The Magistrate shall consider ali factors relating to the detention including the length of detention and the nature of the interrogation.

vii. The actual recording of the Lie Detector Test shall be done in an independent agency (such as a hospital) and conducted in the presence of a lawyer.

viii. A full medical and factual narration of manner of the information received must be taken on record.

G. Model Post-Mortem Report Form

(Read carefully the instructions at Appendix 'A')

NAME OF INSTITUTION _____

Post Mortem Report No. _____ Date _____

Conducted by Dr. _____

Date & Time of receipt of the body and Inquest papers for Autopsy

_____

Date & Time of commencement of Autopsy _____

Time of completion of Autopsy_____

Date & Time of examination of the dead body at Inquest (as per Inquest Report)

_____

Name & Address of the person _____

video recording the Autopsy_____

Note: The tape should be duly sealed, signed and dated and sent to the National Human Rights Commission, Sardar Patel Bhawan, Sansad Marg, New Delhi.

CASE PARTICULARS

1. (a) Name of deceased and as entered in the Jail or Police record

_____

(b) S/O, D/O, W/O _____

(c) Address : _____

2. Age (Approx) :_____ yrs; Sex : Male/Female

3. Body brought by (Name and rank of Police officials)

(i) _____

(ii) _____

of Police Station _____

4. Identified by (Names & addresses of relatives/persons acquainted)

(i) _____

(ii) _____

IF HOSPITAL DEAD BODIES - (particulars as per hospital records)

Date & Time of Admission in Hospital _____

Date & Time of Death in Hospital _____

Central Registration No. of Hospital _____

SCHEDULE OF OBSERVATIONS

(A) GENERAL

(l) Height _____ cms. (2) Weight _____ Kgs.

(3) Physique - (a) lean/ medium / obese

(b) Well built/average built/poor built/emaciated

(4) Identification features (if body is unidentified)

(i) _____

(ii) _____

(iii) Finger prints be taken on seperate sheet and attached by the doctor.

(5) Description of clothes worn - important features:

(6) Post-mortem Changes :

(a) As seen during inquest

Whether rigor mortis present _____

Temperature (Rectal) _____

Others _____

(b) As seen at Autopsy -

(7) (a) External general appearance –

(b) State of eyes

(c) Natural orifices

(B) EXTERNAL INJURIES:

(Mention Type, Shape, Length x Breadth & Depth of each injury and its relation to important body landmark. Indicate which injuries are fresh and which are old and their duration.)

Instructions :-

(i) Injuries be given serial number and mark similarly on the diagrams attached.

(ii) In stab injuries, mention angles, margins and direction inside body.

(iii) In fire arm injuries, mention about effects of fire also.

C) INTERNAL EXAMINATION

1. HEAD

(a) Scalp findings

(b) Skull (Describe fractures here & show them on body diagram enclosed)

(c) Meninges, meningeal spaces & Cerebral vessels(Hemorrhage & its locations, abnormal smell etc. be noted)

(d) Brain findings & Wt. (Wt. _____ gms.)

(e) Orbital, nasal & aural cavities - findings.

2. NECK

- Mouth, Tongue & Pharynx
- Larynx & Vocal cords
- Condition of neck tissues
- Thyroid & other cartilage conditions
- Trachea

3. CHEST

- Ribs and Chest wall
- Oesophagus
- Trachea & Bronchial Tree-Heart findings & Wt. _____ .

Pleural Cavities -R -

- L

Lungs findings & Wt. - Rt. _____ gms. & Lt. _____ gms.

-Pericardial Sac

- Heart findings & Wt. _____

-Large blood vessels

4. Abdomen

- Condition of abdominal wall
- Peritoneum & Peritoneal cavity
- Stomach (wall condition, contents & smell) (Weight _____ gms.)
- Small intestines including appendix
- Large intestines & Mesentric vessels
- Liver including gall bladder (wt. _____ gms)
- Spleen (wt. _____ gms.)
- Pancreas

- Kidneys finding & Wt. - Rt. _____ gms. & Lt. _____ gms.
- Bladder & urethra
- Pelvic cavity tissues
- Pelvic Bones
- Genital organs (Note the condition of vagina, scrotum, presence of foreign body, presence of foetus, semen or any other fluid, and contusion, abrasion in and round genital organs).

5. SPINAL COLUMN & SPINAL CORD (To be opened where indicated)

OPINION

i) Probable time since death (keep all factors including observations at inquest)

ii) Cause & manner of death- The cause of death to the best of my knowledge and belief is :-

(a) Immediate cause –

(b) Due to –

(c) Which of the injuries are ante-mortem/post-mortem and duration if antemortem ?

(d) Manner of causation of injuries

(e) Whether injuries (individually or collectively) are sufficient to cause death in ordinary course of nature or not ?

iii) Any other

SPECIMENS COLLECTED & HANDED OVER (Please tick)

(a) Viscera (Stomach with contents, small intestine with contents, sample of liver, kidney (one half of each), spleen, sample of blood on gauze piece (dried), any other viscera, preservative used)

(b) Clothes

(c) Photographs (Video cassettes in case of custody deaths), finger prints etc)

(d) Foreign body (like bullet, ligature etc.)

(e) Sample of preservative in cases of posioning.

(f) f) Sample of seal

(g) Inquest papers (mention total number & initial them)

(h) Slides from vagina, semen or any other material

PM report in original, ____inquest papers, dead body, clothings and other articles (mention there) duly sealed (Nos. ___) handed over to police official _____ No. _____ of PS _____ whose signatures are herewith.

Signature:_____

Name of Medical Officer _____

(in block letters) _____

Designation _____

SEAL

SOURCE: http://www.nhrc.nic.in/

APPENDIX :

1. Model autopsy protocol

A. Introduction

Difficult or sensitive cases should ideally be the responsibility of an objective, experienced, well-equipped and well-trained prosecutor (the person performing the autopsy and preparing the written report) who is separate from any potentially involved political organization or entity. Unfortunately, this ideal is often unattainable. This proposed model autopsy protocol includes a comprehensive checklist of the steps in a basic forensic postmortem examination that should be followed to the extent possible given the resources available. Use of this autopsy protocol will permit early and final resolution of potentially controversial cases and will thwart the speculation and innuendo that are fueled by unanswered, partially answered or poorly answered questions in the investigation of an apparently suspicious death.

This model autopsy protocol is intended to have several applications and may be of value to the following categories of individuals:

(a) Experienced forensic pathologists may follow this model autopsy protocol to ensure a systematic examination and to facilitate meaningful positive or negative criticism by later observers. While trained pathologists may justifiably abridge certain aspects of the postmortem examination or written descriptions of their findings in routine cases, abridged examinations or reports are never appropriate in potentially controversial cases. Rather, a systematic and comprehensive examination and report are required to prevent the omission or loss of important details;

(b) General pathologists or other physicians who have not been trained in forensic pathology but are familiar with basic postmortem examination techniques may supplement their customary autopsy procedures with this model autopsy protocol. It may also alert them to situations in which they should seek consultation, as written material cannot replace the knowledge gained through experience;

(c) Independent consultants whose expertise has been requested in observing, performing or reviewing an autopsy may cite this model autopsy protocol and its proposed minimum criteria as a basis for their actions or opinions;

(d) Governmental authorities, international political organizations, law enforcement agencies, families or friends of decedents, or representatives of potential defendants charged with responsibility for a death may use this model autopsy protocol to establish appropriate procedures for the postmortem examination prior to its performance;

(e) Historians, journalists, attorneys, judges, other physicians and representatives of the public may also use this model autopsy protocol as a benchmark for evaluating an autopsy and its findings;

(f) Governments or individuals who are attempting either to establish or upgrade their medico-legal system for investigating deaths may use this model autopsy protocol as a guideline, representing the procedures and goals to be incorporated into an ideal medico legal system.

While performing any medico legal death investigation, the prosecutor should collect information that will establish the identity of the deceased, the time and place of death, the cause of death, and the manner or mode of death (homicide, suicide, accident or natural).

It is of the utmost importance that an autopsy performed following a controversial death be thorough in scope. The documentation and recording of the autopsy findings should be equally thorough so as to permit meaningful use of the autopsy results (see annex II, below). It is important to have as few omissions or discrepancies as possible, as proponents of different interpretations of a case may take advantage of any perceived shortcomings in the investigation. An autopsy performed in a controversial death should meet certain minimum criteria if the autopsy report is to be proffered as meaningful or conclusive by the prosecutor, the autopsy's sponsoring agency or governmental unit, or anyone else attempting to make use of such an autopsy's findings or conclusions.

This model autopsy protocol is designed to be used in diverse situations. Resources such as autopsy rooms, X-ray equipment or adequately trained personnel are not available everywhere. Forensic pathologists must operate under widely divergent political systems. In addition, social and religious customs vary widely throughout the world; an autopsy is an expected and routine procedure in some areas, while it is abhorred in others. A prosecutor, therefore, may not always be able to follow all of the steps in this protocol when performing autopsies. Variation from this protocol may be inevitable or even preferable in some cases. It is suggested, however, that any major deviations, with the supporting reasons, should be noted.

It is important that the body should be made available to the prosecutor for a minimum of 12 hours in order to assure an adequate and unhurried examination. Unrealistic limits or conditions are occasionally placed upon the prosecutor with respect to the length of time permitted for the examination or the circumstances under which an examination is allowed. When conditions are imposed, the prosecutor should be able to refuse to perform a compromised examination and should prepare a report explaining this position. Such a refusal should not be interpreted as indicating that an examination was unnecessary or inappropriate. If the prosecutor decides to proceed with the examination notwithstanding difficult conditions or circumstances, he or she should include in the autopsy report an explanation of the limitations or impediments.

Certain steps in this model autopsy protocol have been emphasized by the use of boldface type. These represent the most essential elements of the protocol.

B. Proposed model autopsy protocol

1. Scene investigation

The prosecutor(s) and medical investigators should have the right of access to the scene where the body is found. The medical personnel should be notified immediately to assure that no alteration of the body has occurred. If access to the scene was denied, if the body was altered or if information was withheld, this should be stated in the prosecutor's report.

A system for co-ordination between the medical and non-medical investigators (e.g. law enforcement agencies) should be established. This should address such issues as how the prosecutor will be notified and who will be in charge of the scene. Obtaining certain types of evidence is often the role of the non-medical investigators, but the medical investigators who have access to the body at the scene of death should perform the following steps:

(a) Photograph the body as it is found and after it has been moved;

(b) Record the body position and condition, including body warmth or coolness, lividity and rigidity;

(c) Protect the deceased's hands, e.g. with paper bags;

(d) Note the ambient temperature. In cases where the time of death is an issue, rectal temperature should be recorded and any insects present should be collected for forensic entomological study. Which procedure is applicable will depend on the length of the apparent postmortem interval;

(e) Examine the scene for blood, as this may be useful in identifying suspects;

(f) Record the identities of all persons at the scene;

(g) Obtain information from scene witnesses, including those who last saw the decedent alive, and when, where and under what circumstances. Interview any emergency medical personnel who may have had contact with the body;

(h) Obtain identification of the body and other pertinent information from friends or relatives. Obtain the deceased's medical history from his or her physician(s) and hospital charts, including any previous surgery, alcohol or drug use, suicide attempts and habits;

(i) Place the body in a body pouch or its equivalent. Save this pouch after the body has been removed from it;

(j) Store the body in a secure refrigerated location so that tampering with the body and its evidence cannot occur;

(k) Make sure that projectiles, guns, knives and other weapons are available for examination by the responsible medical personnel;

(l) If the decedent was hospitalized prior to death, obtain admission or blood specimens and any X-rays, and review and summarize hospital records;

(m) Before beginning the autopsy, become familiar with the types of torture or violence that are prevalent in that country or locale (see annex III).

2. Autopsy

The following Protocol should be followed during the autopsy:

(a) Record the date, starting and finishing times, and place of the autopsy (a complex autopsy may take as long as an entire working day);

(b) Record the name(s) of the prosecutor(s), the participating assistant(s), and all other persons present during the autopsy, including the medical and/or scientific degrees and professional, political or administrative affiliations(s) of each. Each person's role in the autopsy should be indicated, and one person should be designated as the principal prosecutor who will have the authority to direct the performance of the autopsy. Observers and other team members are subject to direction by, and should not interfere with, the principal prosecutor. The time(s) during the autopsy when each person is present should be included. The use of a "sign-in" sheet is recommended;

(c) Adequate photographs are crucial for thorough documentation of autopsy findings:

(i) Photographs should be in colour (transparency or negative/print), in focus, adequately illuminated, and taken by a professional or good quality camera. Each photograph should contain a ruled reference scale, an identifying case name or number, and a sample of standard grey. A description of the camera (including the lens "f-number" and focal length), film and the lighting system must be included in the autopsy report. If more than one camera is utilized, the identifying information should be recorded for each. Photographs should also include information indicating which camera took each picture, if more than one camera is used. The identity of the person taking the photographs should be recorded;

(ii) Serial photographs reflecting the course of the external examination must be included. Photograph the body prior to and following undressing, washing or cleaning and shaving;

(iii) Supplement close-up photographs with distant and/or immediate range photographs to permit orientation and identification of the close-up photographs;

(iv) Photographs should be comprehensive in scope and must confirm the presence of all demonstrable signs of injury or disease commented upon in the autopsy report;

(v) Identifying facial features should be portrayed (after washing or cleaning the body), with photographs of a full frontal aspect of the face, and right and left profiles of the face with hair in normal position and with hair retracted, if necessary, to reveal the ears;

(d) Radiograph the body before it is removed from its pouch or wrappings. X-rays should be repeated both before and after undressing the body. Fluoroscopy may also be performed. Photograph all X-ray films;

(i) Obtain dental X-rays, even if identification has been established in other ways;

(ii) Document any skeletal system injury by X-ray. Skeletal X-rays may also record anatomic defects or surgical procedures. Check especially for fractures of the fingers, toes and other bones in the hands and feet. Skeletal X-rays may also aid in the identification of the deceased, by detecting identifying characteristics, estimating age and height, and determining sex and race. Frontal sinus films should also be taken, as these can be particularly useful for identification purposes;

(iii) Take X-rays in gunshot cases to aid in locating the projectile(s). Recover, photograph and save any projectile or major projectile fragment that is seen on an X-ray. Other radio-

opaque objects (pacemakers, artificial joints or valves, knife fragments etc.) documented with X-rays should also be removed, photographed and saved;

(iv) Skeletal X-rays are essential in children to assist in determining age and developmental status;

(e) Before the clothing is removed, examine the body and the clothing. Photograph the clothed body. Record any jewellery present;

(f) The clothing should be carefully removed over a clean sheet or body pouch. Let the clothing dry if it is bloody or wet. Describe the clothing that is removed and label it in a permanent fashion. Either place the clothes in the custody of a responsible person or keep them, as they may be useful as evidence or for identification;

(g) The external examination, focusing on a search for external evidence of injury is, in most cases, the most important portion of the autopsy;

(i) Photograph all surfaces - 100 per cent of the body area. Take good quality, well-focused, colour photographs with adequate illumination;

(ii) Describe and document the means used to make the identification. Examine the body and record the deceased's apparent age, length, weight, sex, head hair style and length, nutritional status, muscular development and colour of skin, eyes and hair (head, facial and body);

(iii) In children, measure also the head circumference, crown-rump length and crown-heel length;

(iv) Record the degree, location and fixation of rigor and livor mortis;

(v) Note body warmth or coolness and state of preservation; note any decomposition changes, such as skin slippage. Evaluate the general condition of the body and note adipocere formation, maggots, eggs or anything else that suggests the time or place of death;

(vi) With all injuries, record the size, shape, pattern, location (related to obvious anatomic landmarks), colour, course, direction, depth and structure involved. Attempt to distinguish injuries resulting from therapeutic measures from those unrelated to medical treatment. In the description of projectile wounds, note the presence or absence of soot, gunpowder, or singeing. If gunshot residue is present, document it photographically and save it for analysis. Attempt to determine whether the gunshot wound is an entry or exit wound. If an entry wound is present and no exit wound is seen, the projectile must be found and saved or accounted for. Excise wound tract tissue samples for microscopic examination. Tape together the edges of knife wounds to assess the blade size and characteristics;

(vii) Photograph all injuries, taking two colour pictures of each, labelled with the autopsy identification number on a scale that is oriented parallel or perpendicular to the injury. Shave hair where necessary to clarify an injury, and take photographs before and after shaving. Save all hair removed from the site of the injury. Take photographs before and after washing the site of any injury. Wash the body only after any blood or material that may have come from an assailant has been collected and saved;

(viii) Examine the skin. Note and photograph any scars, areas of keloid formation, tattoos, prominent moles, areas of increased or decreased pigmentation, and anything distinctive or unique such as birthmarks. Note any bruises and incise them for delineation of their extent. Excise them for microscopic examination. The head and genital area should be checked with special care. Note any injection sites or puncture wounds and excise them to use for toxicological evaluation. Note any abrasions and excise them; microscopic sections may be useful for attempting to date the time of injury. Note any bite marks; these should be photographed to record the dental pattern, swabbed for saliva testing (before the body is washed) and excised for microscopic examination. Bite marks should also be analysed by a forensic odontologist, if possible. Note any burn marks and attempt to determine the cause (burning rubber, a cigarette, electricity, a blowtorch, acid, hot oil etc.). Excise any suspicious areas for microscopic examination, as it may be possible to distinguish microscopically between burns caused by electricity and those caused by heat;

(ix) Identify and label any foreign object that is recovered, including its relation to specific injuries. Do not scratch the sides or tip of any projectiles. Photograph each projectile and large projectile fragment with an identifying label, and then place each in a sealed, padded and labelled container in order to maintain the chain of custody;

(x) Collect a blood specimen of at least 50 cc from a subclavian or femoral vessel;

(xi) Examine the head and external scalp, bearing in mind that injuries may be hidden by the hair. Shave hair where necessary. Check for fleas and lice, as these may indicate unsanitary conditions prior to death. Note any alopecia as this may be caused by malnutrition, heavy metals (e.g. thallium), drugs or traction. Pull, do not cut, 20 representative head hairs and save them, as hair may also be useful for detecting some drugs and poisons;

(xii) Examine the teeth and note their condition. Record any that are absent, loose or damaged, and record all dental work (restorations, fillings etc.), using a dental identification system to identify each tooth. Check the gums for periodontal disease. Photograph dentures, if any, and save them if the decedent's identity is unknown. Remove the mandible and maxilla if necessary for identification. Check the inside of the mouth and note any evidence of trauma, injection sites, needle marks or biting of the lips, cheeks or tongue. Note any articles or substances in the mouth. In cases of suspected sexual assault, save oral fluid or get a swab for spermatozoa and acid phosphatase evaluation. (Swabs taken at the tooth-gum junction and samples from between the teeth provide the best specimens for identifying spermatozoa.) Also take swabs from the oral cavity for seminal fluid typing. Dry the swabs quickly with cool, blown air if possible, and preserve them in clean plain paper envelopes. If rigor mortis prevents an adequate examination, the masseter muscles may be cut to permit better exposure;

(xiii) Examine the face and note if it is cyanotic or if petechiae are present;

a. Examine the eyes and view the conjunctiva of both the globes and the eyelids. Note any petechiae in the upper or lower eyelids. Note any scleral icterus. Save contact lenses, if any are present. Collect at least 1 ml of vitreous humor from each eye;

b. Examine the nose and ears and note any evidence of trauma, haemorrhage or other abnormalities. Examine the tympanic membranes;

(xiv) Examine the neck externally on all aspects and note any contusions, abrasions or petechiae. Describe and document injury patterns to differentiate manual, ligature and hanging strangulation. Examine the neck at the conclusion of the autopsy, when the blood has drained out of the area and the tissues are dry;

(xv) Examine all surfaces of the extremities: arms, forearms, wrists, hands, legs and feet, and note any "defence" wounds. Dissect and describe any injuries. Note any bruises about the wrists or ankles that may suggest restraints such as handcuffs or suspension. Examine the medial and lateral surfaces of the fingers, the anterior forearms and the backs of the knees for bruises;

(xvi) Note any broken or missing fingernails. Note any gunpowder residue on the hands, document photographically and save it for analysis. Take fingerprints in all cases. If the decedent's identity is unknown and fingerprints cannot be obtained, remove the "glove" of the skin, if present. Save the fingers if no other means of obtaining fingerprints is possible. Save fingernail clippings and any under-nail tissue (nail scrapings). Examine the fingernail and toenail beds for evidence of objects having been pushed beneath the nails. Nails can be removed by dissecting the lateral margins and proximal base, and then the undersurface of the nails can be inspected. If this is done, the hands must be photographed before and after the nails are removed. Carefully examine the soles of the feet, noting any evidence of beating. Incise the soles to delineate the extent of any injuries. Examine the palms and knees, looking especially for glass shards or lacerations;

(xvii) Examine the external genitalia and note the presence of any foreign material or semen. Note the size, location and number of any abrasions or contusions. Note any injury to the inner thighs or peri-anal area. Look for peri-anal burns;

(xviii) In cases of suspected sexual assault, examine all potentially involved orifices. A speculum should be used to examine the vaginal walls. Collect foreign hair by combing the pubic hair. Pull and save at least 20 of the deceased's own pubic hairs, including roots. Aspirate fluid from the vagina and/or rectum for acid phosphatase, blood group and spermatozoa evaluation. Take swabs from the same areas for seminal fluid typing. Dry the swabs quickly with cool, blown air if-possible, and preserve them in clean plain paper envelopes;

(xix) The length of the back, the buttocks and extremities including wrists and ankles must be systematically incised to look for deep injuries. The shoulders, elbows, hips and knee joints must also be incised to look for ligamentous injury;

(h) The internal examination for internal evidence of injury should clarify and augment the external examination;

(i) Be systematic in the internal examination. Perform the examination either by body regions or by systems, including the cardiovascular, respiratory, biliary, gastrointestinal, reticuloendothelial, genitourinary, endocrine, musculoskeletal, and central nervous systems. Record the weight, size, shape, colour and consistency of each organ, and note any neoplasia, inflammation, anomalies, haemorrhage, ischemia, infarcts, surgical procedures or injuries. Take sections of normal and any

abnormal areas of each organ for microscopic examination. Take samples of any fractured bones for radiographic and microscopic estimation of the age of the fracture;

(ii) Examine the chest. Note any abnormalities of the breasts. Record any rib fractures, noting whether cardiopulmonary resuscitation was attempted. Before opening, check for pneumothoraces. Record the thickness of subcutaneous fat. Immediately after opening the chest, evaluate the pleural cavities and the pericardial sac for the presence of blood or other fluid, and describe and quantify any fluid present. Save any fluid present until foreign objects are accounted for. Note the presence of air embolism, characterized by frothy blood within the right atrium and right ventricle. Trace any injuries before removing the organs. If blood is not available at other sites, collect a sample directly from the heart. Examine the heart, noting degree and location of coronary artery disease or other abnormalities. Examine the lungs, noting any abnormalities;

(iii) Examine the abdomen and record the amount of subcutaneous fat. Retain 50 grams of adipose tissue for toxicological evaluation. Note the interrelationships of the organs. Trace any injuries before removing the organs. Note any fluid or blood present in the peritoneal cavity, and save it until foreign objects are accounted for. Save all urine and bile for toxicologic examination;

(iv) Remove, examine and record the quantitative information on the liver, spleen, pancreas, kidneys and adrenal glands. Save at least 150 grams each of kidney and liver for toxicological evaluation. Remove the gastrointestinal tract and examine the contents. Note any food present and its degree of digestion. Save the contents of the stomach. If a more detailed toxicological evaluation is desired, the contents of other regions of the gastrointestinal tract may be saved. Examine the rectum and anus for burns, lacerations or other injuries. Locate and retain any foreign bodies present. Examine the aorta, inferior vena cava and iliac vessels;

(v) Examine the organs in the pelvis, including ovaries, fallopian tubes, uterus, vagina, testes, prostate gland, seminal vesicles, urethra and urinary bladder. Trace any injuries before removing the organs. Remove these organs carefully so as not to injure them artifactually. Note any evidence of previous or current pregnancy, miscarriage or delivery. Save any foreign objects within the cervix, uterus, vagina, urethra or rectum;

(vi) Palpate the head and examine the external and internal surfaces of the scalp, noting any trauma or hemorrhage. Note any skull fractures. Remove the calvarium carefully and note epidural and subdural haematomas. Quantify, date and save any haematomas that are present. Remove the dura to examine the internal surface of the skull for fractures. Remove the brain and note any abnormalities. Dissect and describe any injuries. Cerebral cortical atrophy, whether focal or generalized, should be specifically commented upon;

(vii) Evaluate the cerebral vessels. Save at least 150 grams of cerebral tissue for toxicological evaluation. Submerge the brain in fixative prior to examination, if this is indicated;

(viii)Examine the neck after the heart and brain have been removed and the neck vessels have been drained. Remove the neck organs, taking care not to fracture the hyoid bone. Dissect and describe any injuries. Check the mucosa of the larynx, pyriform sinuses and esophagus, and note any petechiae, edema or burns caused by corrosive substances. Note any articles or substances

within the lumina of these structures. Examine the thyroid gland. Separate and examine the parathyroid glands, if they are readily identifiable;

(ix) Dissect the neck muscles, noting any haemorrhage. Remove all organs, including the tongue. Dissect the muscles from the bones and note any fractures of the hyoid bone or thyroid or cricoid cartilages;

(x) Examine the cervical, thoracic and lumbar spine. Examine the vertebrae from their anterior aspects and note any fractures, dislocations. Compressions or haemorrhages. Examine the vertebral bodies. Cerebrospinal fluid may be obtained if additional toxicological evaluation is indicated;

(xi) In cases in which spinal injury is suspected, dissect and describe the spinal cord. Examine the cervical spine anteriorly and note any haemorrhage in the paravertebral muscles. The posterior approach is best for evaluating high cervical injuries. Open the spinal canal and remove the spinal cord. Make transverse sections every 0.5 cm and note any abnormalities;

(i) After the autopsy has been completed, record which specimens have been saved. Label all specimens with the name of the deceased, the autopsy identification number, the date and time of collection, the name of the prosecutor and the contents. Carefully preserve all evidence and record the chain of custody with appropriate release forms;

(i) Perform appropriate toxicologic tests and retain portions of the tested samples to permit retesting;

a. Tissues: 150 grams of liver and kidney should be saved routinely. Brain, hair and adipose tissue may be saved for additional studies in cases where drugs, poisons or other toxic substances are suspected;

b. Fluids: 50 cc (if possible) of blood (spin and save serum in all or some of the tubes), all available urine, vitreous humor and stomach contents should be saved routinely. Bile, regional gastrointestinal tract contents and cerebrospinal fluid should be saved in cases where drugs, poisons or toxic substances are suspected. Oral, vaginal and rectal fluid should be saved in cases of suspected sexual assault;

(ii) Representative samples of all major organs, including areas of normal and any abnormal tissue, should be processed histologically and stained with hematoxylin and eosin (and other stains as indicated). The slides, wet tissue and paraffin blocks should be kept indefinitely;

(iii) Evidence that must be saved includes:

a. All foreign objects, including projectiles, projectile fragments, pellets, knives and fibers. Projectiles must be subjected to ballistic analysis;

b. All clothes and personal effects of the deceased, worn by or in the possession of the deceased at the time of death;

c. Fingernails and under nail scrapings;

d. Hair, foreign and pubic, in cases of suspected sexual assault;

e. Head hair, in cases where the place of death or location of the body prior to its discovery may be an issue;

(j) After the autopsy, all unretained organs should be replaced in the body, and the body should be well embalmed to facilitate a second autopsy in case one is desired at some future point;

(k) The written autopsy report should address those items that are emphasized in boldface type in the protocol. At the end of the autopsy report should be a summary of the findings and the cause of death. This should include the prosecutor's comments attributing any injuries to external trauma, therapeutic efforts, postmortem change, or other causes. A full report should be given to the appropriate authorities and to the deceased's family.

2. Principles on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (the Istanbul Protocol)

UN Office for the High Commissioner for Human Rights, New York and Geneva, 2001

The Commission on Human Rights in its resolution 2000/43 and the UN General Assembly in its resolution 55/89 drew the attention of Governments to the Principles and strongly encouraged Governments to reflect upon the Principles as a useful tool in combating torture.

1. The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment (hereafter torture or other ill-treatment) include the following:

(i) Clarification of the facts and establishment and acknowledgment of individual and State responsibility for victims and their families;

(ii) Identification of measures needed to prevent recurrence;

(iii) Facilitating prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible, and demonstrating the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2. States shall ensure that complaints and reports of torture or ill-treatment shall be promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be undertaken if there are other indications that torture or ill-treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission, investigations by impartial medical or other experts. The

methods used to carry out such investigations shall meet the highest professional standards, and the findings shall be made public.

3. (a) The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry. The persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence.

3. (b) Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as those conducting the investigation.

4. Alleged victims of torture or ill-treatment and their legal representatives shall be informed of, and have access to, any hearing, as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5. (a) In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States shall ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles. Under certain circumstances, professional ethics may require information to be kept confidential. These requirements should be respected.

5. (b) A written report, made within a reasonable time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report shall be made public. It shall also describe in detail specific events that were found to have occurred, the evidence upon which such findings were based, and list the names of witnesses who testified, with the exception of those whose identities have been withheld for

their own protection. The State shall, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

6. (a) Medical experts involved in the investigation of torture or ill-treatment should behave at all times in conformity with the highest ethical standards and in particular shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials.

6. (b) The medical expert should promptly prepare an accurate written report. This report should include at least the following

(i) Circumstances of the interview: name of the subject and names and affiliations of those present at the examination; the exact time and date; the location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); the circumstances of the subject at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

(ii) History: a detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, the times when torture or ill-treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

(iii) Physical and psychological examination: a record of all physical and psychological findings on clinical examination, including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(iv) Opinion: an interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment and/or further examination should be given;

(v) Authorship: the report should clearly identify those carrying out the examination and should be signed.

6. (c) The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. It should also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report should not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such transfer.

3. Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Adopted by General Assembly resolution 37/194 of 18 December 1982

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment. 1

Principle 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

Principle 4

It is a contravention of medical ethics for health personnel, particularly physicians:

(a) To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;

(b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

Principle 6

There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.

1. See the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel. Inhuman or Degrading Treatment or Punishment (resolution 3452 (XXX), annex).
2. Particularly the Universal Declaration of Human Rights (resolution 217 A (III)), the International Covenants on Human Rights (resolution 2200 A (XXI). annex), the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (resolution 3452 (XXX), annex) and the Standard Minimum Rules for the Treatment of Prisoners (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders: report by the Secretariat (United Nations publication, Sales No. E.1956.IV.4, annex I.A)).

4. Declaration of Geneva

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due;

I WILL PRACTISE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour.

World Medical Association International Code of Medical Ethics

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983

DUTIES OF PHYSICIANS IN GENERAL

A PHYSICIAN SHALL	always maintain the highest standards of professional conduct.
A PHYSICIAN SHALL	not permit motives of profit to influence the free and independent exercise of professional judgement on behalf of patients.
A PHYSICIAN SHALL	in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity.
A PHYSICIAN SHALL	deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who e[illegible]ge in fraud or deception.

The following practices are deemed to be unethical conduct:

A. Self advertising by physicians, unless permitted by the laws of the country and the Code of Ethics of the National Medical Association.

B. Paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source.

A PHYSICIAN SHALL	respect the rights of patients, of colleagues, and of other health professionals and shall safeguard patient confidences.
A PHYSICIAN SHALL	act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.
A PHYSICIAN SHALL	use great caution in divulging discoveries or new techniques or treatment through non-professional channels.
A PHYSICIAN SHALL	certify only that which he has personally verified.

DUTIES OF PHYSICIANS TO THE SICK

A PHYSICIAN SHALL	always bear in mind the obligation of preserving human life.
A PHYSICIAN SHALL	owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the physician's capacity he should summon another physician who has the necessary

	ability.
A PHYSICIAN SHALL	preserve absolute confidentiality on all he knows about his patient even after the patient has died.
A PHYSICIAN SHALL	give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

DUTIES OF PHYSICIANS TO EACH OTHER

A PHYSICIAN SHALL	behave towards his colleagues as he would have them behave towards him.
A PHYSICIAN SHALL NOT	entice patients from his colleagues.
A PHYSICIAN SHALL	observe the principles of the "Declaration of Geneva" approved by the World Medical Association.

6. Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002

6. UNETHICAL ACTS: A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical -

6.6 Human Rights: The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights.

7. Declaration of Tokyo

Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment

(As adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975)

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. 'Me decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

8. World Medical Association Declaration on Human Rights and Individual Freedom of Medical Practitioners

(Adopted by the 37th World Medical Assembly Brussels, Belgium, October 1985)

The World Medical Association is in favour of equality of opportunity in medical society activities, medical education and training, employment, and all other aspects of medical professional endeavours regardless of race, colour, religion, creed, ethnic affiliation, national origin, sex, age or political affiliation.

The World Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in national medical associations to any duly registered physician because of race, colour, religion, creed, ethnic affiliation, national origin, sex, age or political affiliation.

The World Medical Association calls upon the medical profession and all individual members of national medical associations to exert every effort to end any instance in which such equal rights, privileges or responsibilities are denied, and

THEREFORE, BE IT RESOLVED that the 37th World Medical Assembly meeting in Brussels, Belgium, October 1985, hereby reaffirms its adherence to these principles.

9. World Medical Association Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment

(Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997)

Preamble

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are prohibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.

2. Primary among these declarations are the World Medical Association's International Code of Medical Ethics, Declaration of Geneva, Declaration of Tokyo, and Resolution on Physician Participation in Capital Punishment; the Standing Committee of European Doctors' Statement of Madrid; the Nordic Resolution Concerning Physician Involvement in Capital Punishment; and, the World Psychiatric Association's Declaration of Hawaii.

3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit support for, or the obligation to protect, doctors who encounter or become aware of such procedures.

Resolution

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organised medical profession:

   i. to encourage doctors to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task;

   ii. to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures; and,

   iii. to extend its support and to encourage other international organisations, as well as the national member associations (NMAs) of the World Medical Association, to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession.

5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon medical doctors to act in contravention to the ethical principles subscribed to by the profession, the WMA finds it necessary:

   i. to protest internationally against any involvement of, or any pressure to involve, medical doctors in acts of torture or other forms of cruel, inhuman or degrading treatment or punishment;

   ii. to support and protect, and to call upon its NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;

   iii. to publicise information about and to support doctors reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures; and,

   iv. to encourage national medical associations to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Declaration.

10. World Medical Association Declaration on Hunger Strikers

(Adopted by the 43rd World Medical Assembly Malta, November 1991and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992)

Preamble

1. The doctor treating hunger strikers is faced with the following conflicting values:

1. There is a moral obligation on every human being to respect the sanctity of life. This is especially evident in the case of a doctor, who exercises his skills to save life and also acts in the best interests of his patients (Beneficence).

2. It is the duty of the doctor to respect the autonomy which the patient has over his person. A doctor requires informed consent from his patients before applying any of his skills to assist them, unless emergency circumstances have arisen in which case the doctor has to act in what is perceived to be the patient's best interests.

2. This conflict is apparent where a hunger striker who has issued clear instructions not to be resuscitated lapses into a coma and is about to die. Moral obligation urges the doctor to resuscitate the patient even though it is against the patient's wishes. On the other hand, duty urges the doctor to respect the autonomy of the patient.

    1. Ruling in favour of intervention may undermine the autonomy which the patient has over himself.

    2. Ruling in favour of non-intervention may result in a doctor having to face the tragedy of an avoidable death.

3. A doctor/patient relationship is said to be in existence whenever a doctor is duty bound, by virtue of his obligation to the patient, to apply his skills to any person, be it in the form of advice or treatment.

    This relationship can exist in spite of the fact that the patient might not consent to certain forms of treatment or intervention.

    Once the doctor agrees to attend to a hunger striker, that person becomes the doctor's patient. This has all the implication and responsibilities inherent in the doctor/patient relationship, including consent and confidentiality.

4. The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare. However, the doctor should clearly state to the patient whether or not he is able to accept the patient's decision to refuse treatment or, in case of coma, artificial feeding, thereby risking death. If the doctor cannot accept the patient's decision to refuse such aid, the patient would then be entitled to be attended by another physician.

11. Guidelines for the Management of Hunger Strikers

Since the medical profession considers the principle of sanctity of life to be fundamental to its practice, the following practical guidelines are recommended for doctors who treat hunger strikers:

1. **Definition**

    A hunger striker is a mentally competent person who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval.

2. **Ethical Behaviour**

    1. A doctor should acquire a detailed medical history of the patient where possible.

2. A doctor should carry out a thorough examination of the patient at the onset of the hunger strike.

3. Doctors or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon him suspending his hunger strike.

4. The hunger striker must be professionally informed by the doctor of the clinical consequences of a hunger strike, and of any specific danger to his own particular case. An informed decision can only be made on the basis of clear communication. An interpreter should be used if indicated.

5. Should a hunger striker wish to have a second medical opinion, this should be granted. Should a hunger striker prefer his treatment to be continued by the second doctor, this should be permitted. In the case of the hunger striker being a prisoner, this should be permitted by arrangement and consultation with the appointed prison doctor.

6. Treating infections or advising the patient to increase his oral intake of fluid (or accept intravenous saline solutions) is often acceptable to a hunger striker. A refusal to accept such intervention must not prejudice any other aspect of the patients health care. Any treatment administered to the patient must be with his approval.

3. **Clear Instructions**

The doctor should ascertain on a daily basis whether or not the patient wishes to continue with his hunger strike. The doctor should also ascertain on a daily basis what the patient's wishes are with regard to treatment should he become unable to make an informed decision. These findings must be recorded in the doctors personal medical records and kept confidential.

4. **Artificial Feeding**

When the hunger striker has become confused and is therefore unable to make an unimpaired decision or has lapsed into a coma, the doctor shall be free to make the decision for his patient as to further treatment which he considers to be in the best interest of that patient, always taking into account the decision he has arrived at during his preceding care of the patient during his hunger strike, and reaffirming article 4 of the preamble of this Declaration.

5. **Coercion**

Hunger strikers should be protected from coercive participation. This may require removal from the presence of fellow strikers.

Family

The doctor has a responsibility to inform the family of the patient that the patient has embarked on a hunger strike, unless this is specifically prohibited by the patient.

12. Resolution on Human Rights

(Adopted by the 42nd World Medical Assembly Rancho Mirage, California, USA, October 1990and amended by the 45th World Medical Assembly Budapest, Hungary, October 1993and by the 46th General Assembly Stockholm, Sweden, September 1994 and by the 47th General Assembly Bali, Indonesia, September 1995)

Having regard to the fact that:

1. The World Medical Association and its member associations have always sought to advance the cause of human rights for all people, and have frequently taken actions endeavoring to alleviate violations of human rights.
2. Members of the medical profession are often amongst the first to become aware of violations of human rights.
3. Medical Associations have an essential role to play in calling attention to such violations in their countries.

The World Medical Association again calls upon its member associations

1 . To review the situation in their own countries so as to ensure that violations are not concealed as a result to fear of reprisals form the responsible authorities and to request strict observance of civil and human rights when violations are discovered.
2. To provide clear ethical advice to doctors working in the prison system.
3. To provide effective machinery for investigating unethical practices by physicians in the field of human rights.
4. To use their best endeavours to ensure that adequate health care is available to all human beings without distinction.
5. To protest alleged human rights violations through communications that urge the humane treatment of prisoners, and that seek the immediate release of those who are imprisoned without just cause.
6. To support individual physicians who call attention to human rights violations in their own countries.

13. World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide

(Adopted by the 51st World Medical Assembly Tel Aviv, Israel, October 1999)

1. Whereas Medical Ethics and Human Rights form an integral part of the work and culture of the medical profession, and
2. Whereas Medical Ethics and Human Rights form an integral part of the history, structure and objectives of the World Medical Association

3. It is hereby resolved that the WMA strongly recommends to Medical Schools world-wide that the teaching of Medical Ethics and Human Rights be included as an obligatory course in their curricula.

14. Resolution on Physician Participation in Capital Punishment

(World Medical Association, September 11, 1981)

Following concern about the introduction of an execution method (lethal injection) which threatened to involve doctors directly in the process of execution, the WMA Secretary-General issued a press statement opposing any involvement of doctors in capital punishment. The 34th Assembly of the WMA, meeting in Lisbon some weeks after the issuing of the press statement, endorsed the Secretary-General's statement in the following terms:

Resolution on physician participation in capital punishment

Resolved, that the Assembly of the World Medical Association endorses the action of the Secretary General in issuing the attached press release on behalf of the World Medical Association condemning physician participation in capital punishment.

Further resolved, that it is unethical for physicians to participate in capital punishment, although this does not preclude physicians certifying death.

Further resolved, that the Medical Ethics Committee keep this matter under active consideration.

Secretary General's press release

The first capital punishment by intravenous injection of lethal dose of drugs was decided to be carried out next week by the court of the State of Oklahoma, USA.

Regardless of the method of capital punishment a State imposes, no physician should be required to be an active participant. Physicians are dedicated to preserving life.

Acting as an executioner is not the practice of medicine and physician services are not required to carry out capital punishment even if the methodology utilizes pharmacological agents or equipment that might otherwise be used in the practice of medicine.

A physician's only role would be to certify death once the State had carried out the capital punishment.

15. The World Medical Association Statement on Forensic Investigations of the Missing

(Adopted by the WMA General Assembly, Helsinki 2003)

A. Preamble

1. Over the last two decades forensic investigations into the aftermath of wars, civil disturbances and oppressive political regimes have developed as a major contributor to international justice and to an understanding of the truth of what happened. These

investigations are often sponsored by NGOs or by IGOs. Although established with enormous goodwill, and calling upon the expertise of committed individuals, there is sometimes a lack of clarity about their role, remit and ethical basis.

2. The International Committee of the Red Cross (ICRC) "The Missing" initiative involving experts from around the world has set out the scientific, ethical and legal principles that should apply to such forensic investigations. National Medical Associations have a role in encouraging compliance with the highest possible ethical and scientific standards.

3. In many countries NMAs will have no role in certifying the qualifications and experience of Forensic Medical Practitioners. However, they can draw the attention of such practitioners to the advice being produced by the ICRC, Amnesty International, Interpol and the United Nations and recommend or require compliance with those standards."

B. Recommendations

4. The WMA calls upon all NMAs to try to ensure that when its members take part in any forensic investigation, especially outside their own country, the investigation is established with a clear mandate according to the highest possible ethical, scientific and legal standards.

5. The WMA calls upon NMAs to develop expertise in the principles collated by the different authorities on forensic investigations including those outlined in the recommendations from the ICRC "The Missing" project, and to help their members ensure that these principles are applied to International Forensic Investigations.

6. The WMA calls upon NMAs to work to ensure that physicians are aware of the standards that should apply to such investigations and to refuse to take part in those that are ethically or otherwise unacceptable.

7. The WMA calls upon NMAs to ensure that their members only participate in investigations that are properly recorded and documented and for which they are afforded legal and other appropriate safeguards by the investigating authority.

8. The WMA calls upon NMAs to work to ensure that information gained from the investigation should be shared with the families of the missing as well as the relevant tribunals in the pursuit of truth and justice.

16. WHO Guidelines To Forensic Medicine Experts

While there are important health benefits flowing from the practice of forensic medicine, its primary purpose is to serve the needs of the justice system. The intention of the part is to focus on ethical principles, which, if observed, will promote and lead to good practice in the disciplines of forensic pathology and clinical forensic medicine. In the absence of good practice, injustice will flourish.

1. General Application of Ethical Principles to Forensic Medicine

1.1 Independence of the forensic service

In many countries, forensic practitioners are involved in the investigation of deaths and injuries that are either actually, or perceived to be, related to the security of the state. Serious conflicts of interest can arise where the state is involved in both perpetrating and investigating them. Imperatives associated with these investigations may easily overwhelm the ability or the desire of the practitioners to think and act may easily overwhelm the ability or the desire of the practitioners to think and act independently and to discharge their medically derived obligations. It is in these circumstances, however, that an understanding of, and adherence to, fundamental principles of medical ethics helps to ensure the proper administration of justice.

The International Code of Medical Ethics of the World Medical Association states that:

A physician shall, in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity.

It is self-evident that the forensic practitioner should be able to come to conclusions without intimidation and in the absence of threat. In practice, unless forensic practitioners enjoy some form of special protection, it will be relatively easy for authorities to promote a particular desire outcome. Investigators, consciously or unconsciously, may coerce or bring considerable pressure to bear on practitioners to provide an interpretation that would wrongly resolve an issue in favour of the state, police or investigators. This is particularly so in cases where national security is threatened (for example, terrorist activities), serious serial offences (for example, multiple murders), or when public interest or anxiety is at a high level. These coercive forces may be particularly strong when the practitioner has a formal relationship with, or accountability to, the investigating authority, or when a close personal relationship has developed between investigator and forensic practitioner. The situation is further complicated because the practitioner has the dual, and often conflicting roles of investigator and doctor.

While organizational structure is no safeguard against the potential abuse of power, there is a strong case for forensic pathologists and clinical forensic physicians to be employed in a structure that provides whatever protection can be afforded against such potential abuse. Such a structure, if effective, will promote confidence in the findings of the practitioner in courts of law and the co0mmunity, and in turn promote confidence in the justice system. Examples of structure arrangements that have the potential to provide an appropriate level of independence for a forensic medical service include establishment of an independent statutory agency, or inclusion of the service as part of a university medical faculty. In the case of a statutory agency, innovative structures could some form of administrative accountability to the judiciary.

In the administration of the forensic service, account should be taken of the following issues:

- ability to provide independent advice in instances where a patient claims to have been injured by police action, or by the action of other servants of the government;
- availability of an appropriate structure and mechanism for all users to make comments or complaints and for those comments and complaints to be dealt with; and
- accountability for the quality, quantity, timeliness and costs of tits services.

1.2 Forensic practitioners as expert witnesses

General requirements for forensic practitioners in meeting the needs of the justice system are to:

- be readily available;
- be familiar with the basic principles and practice of the legal system and with the obligations of those within the system especially the police.
- reliably collect appropriate samples from victims of crime, scenes of crime and suspects, the proper analysis of which can provide results which can be used as evidence in an investigation and prosecution; and
- make reliable clinical and/or post-mortem observations, which form the basis of reasonable assessments and measured expert opinion.

In terms of attendance in court, there are many pitfalls awaiting practitioners as they give evidence of the observations and conclusions. The pitfalls, or the mistakes that can be made, occur in the following areas:

- providing opinions which are at the edge of, or beyond, the expertise of the witness;
- providing opinions that are based on false assumptions or incomplete facts;
- providing opinions based on incomplete or inadequate scientific or medical analysis; and
- providing opinions which are biased, consciously or unconsciously, in favour of one side or the other in the proceedings.

In addition, failures of communication occur between expert witnesses, police and lawyers.

The giving of evidence is the culmination of the forensic practitioner's work in a particular case and there is an obligation to bring to this task the same reasonable care and skill as to other aspects of the practitioner's craft. After all, it is on the basis of the evidence that important decisions will be made affecting the life and liberty of accused persons (in criminal matters) or affection liability and compensation (in civil matters). The words of the eminent forensic pathologist Keith Simpson are apposite[1]:

> Every time a doctor steps into the witness box to give evidence, whether as a young casualty officer or an experienced specialist, s/he needs to make a conscious effort to perform will. The four absolute essentials of success are:

[1] Simpson K. A doctor's guide to court: a handbook on medical evidence, 2nd Edition. London, Butterworths. 1967:51

- preparation—familiarity with the facts of the case and possession of the relevant documents before stepping into the box;
- clear exposition—the ability to express things lucidly and briefly in simple words;
- confining oneself to one's field of competence; and
- tolerance and courtesy.

While the above may appear to be the beginnings of a quality manual on the giving of evidence, it is also apparent that an important value is at stake; the truth of what the forensic practitioner saw and concluded must be conveyed to the court impartially, ensuring that a balanced interpretation of the findings is given. Simpson's criteria still apply, but the increasing complexity of medicine and science and the more rigorous challenging of expert evidence by lawyers means they no longer cover the field. Furthermore, legal procedures may not be adequate in themselves to safeguard a citizen against an unsatisfactory verdict that is based on unsound expert evidence. These factors place on onus on export witnesses to be more active on behalf of their professions or field of expertise to ensure that the best assistance is given to the courts. Experts witnesses, rather than being a passive agent of the party who is instructing them, are required to become more active so that the court can be the beneficiary of the best possible answers to the medical and scientific issues in front of it.

As there is considerable variation between jurisdictions in the laws of evidence, it is difficult to generalize. However, a particular practical application of the obligation to be more actively involved as a witness, is not to accept a direction from a lawyer to simply answer "yes" to "no" to a question if such an answer is misleading. In most jurisdictions, it is possible to bring a judge's attention to such misleading consequences and a to seek his or her guidance on the matter. In bringing the matter to the judge's attention, reference can be made to the usual undertaking given to the court by the witness to tell the truth. In the unlikely event that the judge nevertheless directs the witness to answer "yes" or "no", then the responsibility for the misleading answer passes to the judge.

Apart from the content of the witness's evidence, generally speaking, the value of the export witness's contribution is proportional to the understanding the lawyer has of the subject matter. Insufficient understanding often leads to confusion and wasted time. A pre-trial conference with the instructing advocate or lawyer may be important. A pre-trial conference provides the witness with an opportunity to educate the advocate or lawyer, to interpret medical and scientific terminology and to apprise him or her more carefully of exactly what it is the witness will say.

17. The World Medical Association Resolution On The Responsibility Of Physicians In The Denunciation Of Acts Of Torture Or Cruel Or Inhuman Or Degrading Treatment of Which They Are Aware

Initiated: September 2002
Adopted by the WMA General Assembly, Helsinki 2003

The World Medical Association,

1. Considering the Preamble to the United Nations Charter of 26 June 1945 solemnly proclaiming the faith of the people of the United Nations in the fundamental human rights, in the dignity and value of the human person,
2. Considering the Preamble to the Universal Declaration of Human Rights of 10 December 1948 which states that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind,
3. Considering Article 5 of that Declaration which proclaims that no one shall be subjected to torture or cruel, inhuman or degrading treatment,
4. Considering the American Convention on Human Rights adopted by the Organization of American States on 22 November 1969 and which entered into force on 18 July 1978 and the Inter-American Convention to Prevent and Punish Torture, which entered into force on 28 February 1987,
5. Considering the Declaration of Tokyo, adopted by the WMA in 1975, which reaffirms the prohibition of any form of medical involvement or presence of a physician during torture or inhuman or degrading treatment,
6. Considering the Declaration of Hawaii (World Psychiatric Association), adopted in 1977,
7. Considering the Declaration of Kuwait (International Conference of Islamic Medical Associations), adopted in 1981,
8. Considering the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on 18 December 1982, and particularly Principle 2, which states: "*It is a gross contravention of medical ethics... for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment...*",
9. Considering the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on December 1984,

10. Considering the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the Council of Europe on 26 June 1987 and entered into force on 1 February 1989,

11. Considering the Resolution on Human Rights adopted by the WMA in Rancho Mirage, in October 1990 during the 42nd General Assembly and amended by the 45th, 46th and 47th General Assemblies,

12. Considering the Declaration of Hamburg, adopted by the WMA in November 1997 during the 49th General Assembly and calling on physicians to protest individually against ill-treatment and on national and international medical organizations to support physicians in such actions,

13. Considering the Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), adopted by the United Nations General Assembly on 4 December 2000,

Recognizing

14. That careful and consistent denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity,

15. That physicians, by ascertaining the sequelae and treating the victims of torture, either early or late after the event, are privileged witnesses of this violation of human rights,

16. That the victims, because of the psychological sequelae from which they suffer or the pressures brought on them, are often unable to formulate by themselves complaints against those responsible for the ill-treatment they have undergone,

17. That the non-denunciation of acts of torture may be considered as a form of tolerance thereof and of non-assistance to the victims,

18. That nevertheless there is no consistent and explicit reference in the professional codes of medical ethics and legislative texts of the obligation upon physicians to report or denounce acts of torture or inhuman or degrading treatment of which they are aware,

Recommends that National Medical Associations

19. Support the adoption in their country of ethical rules and legislative provisions:

    19.1 aimed at affirming the ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of which they are aware; depending on the circumstances, the report or denunciation would be addressed to medical, legal, national or international authorities, to non-governmental organizations or to the International Criminal Court. Doctors should use their discretion in this matter, bearing in mind paragraph 68 of the Istanbul Protocol.

    19.2 establishing, to that effect, an ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible with the subject's

consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.

19.3 cautioning physicians to avoid putting individuals in danger by reporting on a named basis a victim who is deprived of freedom, subjected to constraint or threat or in a compromised psychological situation.

20. Disseminate to physicians the Istanbul Protocol.

21. Promote their training on the identification of different modes of torture and their sequelae.

22. Place at their disposal all useful information on reporting procedures, particularly to the national authorities, nongovernmental organisations and the International Criminal Court.

Istanbul Protocol, paragraph 68: "In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.

17.9.2003

18. Nurses' Role in the Care of Detainees and Prisoners

ICN Position:

The International Council of Nurses endorses the United Nations Universal Declaration of Human Rights, 1948 and the Geneva Convention of 1949[1] and the additional protocols and therefore asserts that:

- Prisoners and detainees have the right to health care and humane treatment.
- We condemn interrogation procedures and any act or behaviour harmful to mental and physical health.
- Prisoners and detainees have a right to clear and sufficient information; to refuse treatment or diagnostic procedures; and to die with dignity and in a peaceful manner.

Nurses' primary responsibility is to those people who require nursing care[1]. In caring for detainees and prisoners nurses are expected to adhere to ethical principles and the following:

- Nurses who have knowledge of abuse and maltreatment of detainees and prisoners take appropriate action to safeguard their rights.
- Nurses employed in prison health services do not assume functions of prison security personnel, such as body searches for the purpose of prison security.
- Nurses participate in clinical research on prisoners and detainees only with the prisoner or detainee's informed consent.
- Nurses collaborate with other health professionals and prison authorities to reduce the impact of crowded and unhealthy prison environments on transmission of infectious diseases such HIV/AIDS and tuberculosis.
- Nurses abstain from using their nursing knowledge and skills in any manner, which violates the rights of detainees and prisoners.
- Nurses advocate for safe humane treatment of detainees and prisoners including clean water, adequate food and other basic necessities of life.

N believes National Nurses Associations (NNAs) and individual nurses should be protected from ...sals related to advocacy for or providing care to detainees and prisoners. Furthermore, NNAs ...uld ensure prison nurses have access to confidential advice, counsel and support.

Background:

The United Nations *Universal Declaration of Human Rights, 1948,* states that everyone is entitled to all the rights and freedoms without distinction of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and no one shall be subjected to cruel, inhumane or degrading treatment.

The ethical obligations of health professionals are addressed in the *Principles of Medical Ethics Relevant to the Role of Health Personnel, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishmen*[2]. These and other instruments such as the Istanbul Protocol[3] make clear that health professionals have a moral duty to protect the physical and mental health of prisoners and detainees.

The *ICN Code of Ethics for Nurses* affirms that nurses have a fundamental responsibility to promote health, to prevent illness, to restore health and to alleviate suffering to all people, ...cluding detainees and prisoners. Nurses working in prison systems must observe the *Standard*

---

[1] International Council of Nurses, ICN *Code of Ethics for Nurses*, Geneva, ICN, 2005.

[2] Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. (www.unhchr.ch/html/menu3/b/h)

[3] Manual on the Effective Investigation and Documentation of To... and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) Submitted to the: U...ed Nations High Commissioner for Human Rights 9 September 1999.

Minimum Rules for the Treatment of Prisoners[4], which require that health services must be available to prisoners without discrimination.

Adopted in 1998, Revised in 2006

(Replaces previous ICN Position: "The Nurse's Role in the Care of Detainees and Prisoners", adopted 1975)

19. Torture, Death Penalty and Participation by Nurses in Executions

ICN Position:

The International Council of Nurses strongly affirms that nurses should play no voluntary role in any deliberate infliction of physical or mental suffering and should not participate, either directly or indirectly, in the preparation for and the implementation of executions. To do otherwise is a clear violation of nursing's ethical code of practice. The nurse's primary responsibility is to those people who require nursing care.

Nurses have a duty to provide the highest possible level of care to victims of cruel, degrading and inhumane treatment, and should speak up against and oppose any deliberate infliction of pain and suffering. While ICN considers the death penalty to be unacceptable, clearly the nurse's responsibility to a prisoner sentenced to death continues until execution.

ICN urges its member national nurses' associations (NNAs) to lobby for abolition of the death penalty; to actively oppose torture and participation by nurses in executions; and to develop mechanisms to provide nurses with confidential advice and support in caring for prisoners sentenced to death or subjected to torture. ICN pledges to take appropriate action and urges NNAs and individual nurses to do the same in support of nurses who become victims of torture, cruel treatment or even death for upholding the professional ethical conduct and for their work in defending human rights.

ICN believes that all levels of nursing education curricula should include: recognition of human rights issues and violations, such as torture and death penalty; awareness of the use of medical technology including lethal injections for executions; and recognition of the nurse's right to refuse to participate in executions.

Background:

Violations of human rights are pervasive and scientific advances have brought about sophisticated forms of torture. ICN supports the United Nations Universal Declaration of Human Rights[1] and advocates upholding the Convention Against Torture and Other Cruel, Inhuman or Degrading

[4] United Nations (1955), Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Standard Minimum Rules, adopted by the UN 1955.

Treatment or Punishment, the Istanbul Protocol on Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[5].

The ICN Code of Ethics for Nurses states that *...the fundamental responsibility of the nurse is to promote health, prevent illness, to restore health and to alleviate suffering.* However we recognise that nurses are sometimes called upon to perform physical examinations before prisoners' interrogation and torture, to attend torture sessions in order to provide care, and/or to treat the effects of torture. Efforts to regulate and 'humanise' the death penalty or even to 'medicalise' it have led to contradictory legal and ethical problems.

Adopted in 1998

Revised in 2003 and 2006

(Replaces previous ICN Positions "Nurses and Torture", adopted 1989 and "Death penalty and participation by nurses in execution" adopted 1989).

20. Madrid Declaration on Ethical Standards for Psychiatric Practice

Approved by the General Assembly on August 25, 1996 and amended by the General Assembly in Yokohama, Japan, in August 2002

DECLARATION OF MADRID

In 1977, the World Psychiatric Association approved the Declaration of Hawaii, setting out ethical guidelines for the practice of psychiatry. The Declaration was subsequently updated in Vienna in 1983. To reflect the impact of changing social attitudes and new medical developments on the psychiatric profession, the World Psychiatric Association has once again examined and revised some of these ethical standards.

Medicine is both a healing art and a science. The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill and infirm, because of a mental disorder or impairment. Although there may be cultural, social and national differences, the need for ethical conduct and continual review of ethical standards is universal.

As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician, and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.

Ethical behavior is based on the psychiatrist's individual sense of responsibility towards the patient and their judgment in determining what is correct and appropriate conduct. External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.

---

[5] Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) Submitted to the: United Nations High Commissioner for Human Rights 9 September 1999

Psychiatrists should at all times keep in mind the boundaries of the psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity.

It is in this spirit that the World Psychiatric Association approved at the General Assembly on August 25th, 1996, the following ethical standards that should govern the conduct of psychiatrists worldwide.

1. Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.

2. It is the duty of psychiatrists to keep abreast scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.

3. The patient should be accepted as a partner by right in the therapeutic process. The psychiatrist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to personal values and preferences.

4. When the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, or gravely disabled or incompetent, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient.

5. When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when the psychiatrists are involved in third party situations.

6. Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or financial or academic benefits. Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained; as in case of child abuse in these circumstances,

psychiatrists, should whenever possible, first advise the patient about the action to be taken.

7. Research that is not conducted in accordance with the canons of science is unethical. Research activities should be approved by an appropriately constituted ethical committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centers.

Guidelines concerning specific situations

The World Psychiatric Association Ethics Committee's recognizes the need to develop a number of specific guidelines on a number of specific situations. The first five were approved by the General Assembly in Madrid, Spain, on August 25, 1996 and the last by the General Assembly in Hamburg, Germany, on August 8, 1999.

- **Euthanasia:** A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informal decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of a patient may be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness.
- **Torture:** Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.
- **Death Penalty:** Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.
- **Selection of Sex:** Under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of sex selection.
- **Organ Transplantation:** The role of the psychiatrist is to clarify the issues surrounding organ donations and to advise on religious, cultural, social and family factors to ensure that informed and proper decisions be made by all concerned. The psychiatrists should not act as a proxy decision maker for patients nor use psychotherapeutic skills to influence the decision of a patient in these matters. Psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situations of organ transplantation.
- **Psychiatrists addressing the media**. The media has a key role in shaping the attitudes of the community. In all contacts with the media psychiatrists shall ensure that people with mental illness are presented in a manner which preserves their dignity and pride, and

which reduces stigma and discrimination against them. An important role of psychiatrists is to advocate for those people who suffer from mental disorders. As the public perception of psychiatrists and psychiatry reflects on patients, psychiatrists shall ensure that in their contact with the media they represent the profession of psychiatry with dignity. Psychiatrists shall not make announcements to the media about presumed psychopathology on any individuals. In presenting research findings to the media, psychiatrists shall ensure the scientific integrity of the information given and be mindful of the potential impact of their statements on the public perception of mental illness and on the welfare of people with mental disorders.

- **Psychiatrists and discrimination on ethnic or cultural grounds**. Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others is unethical. Psychiatrists shall never be involved or endorse, directly or indirectly, any activity related to ethnic cleansing.

- **Psychiatrists and genetic research and counseling**. Research on the genetic bases of mental disorders is rapidly increasing and more people suffering from mental illness are participating in such research. Psychiatrists involved in genetic research or counseling shall be mindful of the fact that the implication of genetic information are not limited to the individual from whom it was obtained and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned. Psychiatrist shall therefore ensure that:

    - People and families who participate in genetic research do so with a fully informed consent;
    - Any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse;
    - Care is taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings.

Psychiatrists shall only refer people to facilities for diagnostic genetic testing if that facility has:

- Demonstrated satisfactory quality assurance, procedures for such testing;
- Adequate and easily accessible resources for genetic counseling. Genetic counseling with regard to family planning or abortion shall be respectful of the patients' value system, while providing sufficient medical and psychiatric information to aid patients make decisions they consider best for them.

Four Additional Specific Ethical Guidelines

a) Ethics of Psychotherapy in Medicine

Medical treatments of any nature should be administered under the provisions of good practice guidelines regarding their indications, effectiveness, safety, and quality control. Psychotherapy, in its broadest sense, is an accepted component of many medical interactions . In a more specific and restricted sense, psychotherapy utilizes techniques involving verbal and non-

verbal communication and interaction to achieve specified treatment goals in the care of specific disorders. Psychiatrists providing specific forms of psychotherapy must have appropriate training in such techniques. The general guidelines that apply to any medical treatment also apply to specific forms of psychotherapy in regard to its indications and outcomes, positive or negative. The effectiveness of psychotherapy and its place in a treatment plan are important subjects for both researchers and clinicians. Psychotherapy by psychiatrists is a form of treatment for mental and other illnesses and emotional problems. The treatment approach utilized is determined in concert by the doctor and patient and/or the patient's family and/or guardians following a careful history and examination employing all relevant clinical and laboratory studies. The approach employed should be specific to the disease and patient's needs and sensitive to personal, familial, religious and cultural factors. It should be based on sound research and clinical wisdom and have the purpose of removing, modifying or retarding symptoms or disturbed patterns of behavior. It should promote positive adaptations including personal growth and development.

Psychiatrists and other clinicians responsible for a patient have to ensure that these guidelines are fully applied. Therefore, the psychiatrist or other delegated qualified clinician, should determine the indications for psychotherapy and follow its development . In this context the essential notion is that the treatment is the consequence of a diagnosis and both are medical acts performed to take care of an ill person. These two levels of decisions, interventions and responsibilities are similar to other situations in clinical medicine, however this does not exclude other interventions such as rehabilitation which can be administered by non-medical personnel.

6. Like any other treatment in medicine, the prescription of psychotherapy should follow accepted guidelines for obtaining informed consent prior to the initiation of treatment as well as updating it in the course of treatment if goals and objectives of treatment are modified in a significant way.

7. If clinical wisdom, long standing and well-established practice patterns (this takes into consideration cultural and religious issues) and scientific evidence suggest potential clinical benefits to combining medication treatment with psychotherapy this should be brought to the patient's attention and fully discussed.

8. Psychotherapy explores intimate thoughts, emotions and fantasies, and as such may engender intense transference and counter-transference. In a psychotherapy relationship the power is unequally shared between the therapist and patient, and under no circumstances shall the psychotherapist use this relationship to personal advantage or transgress the boundaries established by the professional relationship.

9. At the initiation of psychotherapy, the patient shall be advised that information shared and health records will be kept in confidence except where the patient gives specific informed consent for release of information to third parties, or where a court order may require the production of records. The other exception is where there is a legal requirement to report certain information as in the case of child abuse.

b) Conflict of Interest in Relationship with Industry

Although most organizations and institutions, including the WPA, have rules and regulations governing their relationship with industry and donors, individual physicians are often involved in interactions with the pharmaceutical industry, or other granting agencies that could lead to ethical conflict In these situations psychiatrists should be mindful of and apply the following guidelines.

10. The practitioner must diligently guard against accepting gifts that could have an undue influence on professional work.

11. Psychiatrists conducting clinical trials are under an obligation to disclose to the Ethics Review Board and their research subjects their financial and contractual obligations and benefits related to the sponsor of the study. Every effort should be made to set up review boards composed of researchers, ethicists and community representatives to assure the rights of research subjects are protected.

12. Psychiatrists conducting clinical trials have to ensure that their patients have understood all aspects of the informed consent. The level of education or sophistication of the patient is no excuse for bypassing this commitment. If the patient is deemed incompetent the same rules would apply in obtaining informed consent from the substitute decision maker. Psychiatrists must be cognizant that covert commercial influence on the trial design, promotion of drugs trials without scientific value, breach of confidentiality, and restrictive contractual clauses regarding publication of results may each in different ways encroach upon the freedom of science and scientific information.

c) Conflicts arising with Third Party Payers

The obligations of organizations toward shareholders or the administrator regarding maximization of profits and minimization of costs can be in conflict with the principles of good practice Psychiatrists working in such potentially conflicting environments, should uphold the rights of the patients to receive the best treatment possible.

13. In agreement with the UN Resolution 46/119 of the "Principles for the Protection of Persons with Mental Illness, psychiatrists should oppose discriminatory practices which limit their benefits and entitlements, deny parity curb the scope of treatment, or limit their access to proper medications for patients with a mental disorder.

14. Professional independence to apply best practice guidelines and clinical wisdom in upholding the welfare of the patient should be the primary considerations for the psychiatrist. It is also the duty of the psychiatrist to protect the patient privacy and confidentiality as part of preserving the sanctity and healing potential of the doctor-patient relationship.

d) Violating the Clinical Boundaries and Trust between Psychiatrists and Patients

The psychiatrist-patient relationship may be the only relationship that permits an exploration of the deeply personal and emotional space, as granted by the patient. Within this relationship, the psvchiatrist's respect for the humanity and dignity of the patient builds a

foundation of trust that is essential for a comprehensive treatment plan. The relationship encourages the patient to explore deeply held strengths, weaknesses, fears, and desires, and many of these might be related to sexuality. Knowledge of these characteristics of the patient places the psychiatrist in a position of advantage that the patient allows on the expectation of trust and respect. Taking advantage of that knowledge by manipulating the patient's sexual fears and desires in order to obtain sexual access is a breach of the trust, regardless of consent. In the therapeutic relationship, consent on the part of the patient is considered vitiated by the knowledge the psychiatrists possesses about the patient and by the power differential that vests the psychiatrist with special authority over the patient. Consent under these circumstances will be tantamount to exploitation of the patient.

The latent sexual dynamics inherent in all relationships can become manifest in the course of the therapeutic relationship and if they are not properly handled by the therapist can produce anguish to the patient. This anguish is likely to become more pronounced if seductive statements and inappropriate non-verbal behavior are used by the therapist. Under no circumstances, therefore, should a psychiatrist get involved with a patient in any form of sexual behavior, irrespective of whether this behavior is initiated by the patient or the therapist.

21. Universal Declaration of Human Rights, 1948

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.
3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

22. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984

The States Parties to this Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that those rights derive from the inherent dignity of the human person,

Considering the obligation of States under the Charter, in particular Article 55, to promote universal respect for, and observance of, human rights and fundamental freedoms,

Having regard to article 5 of the Universal Declaration of Human Rights and article 7 of the International Covenant on Civil and Political Rights, both of which provide that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment,

Having regard also to the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the General Assembly on 9 December 1975,

Desiring to make more effective the struggle against torture and other cruel, inhuman or degrading treatment or punishment throughout the world,

Have agreed as follows:

PART I

Article 1

1. For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.
2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.

Article 2

1. Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.
2. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political in stability or any other public emergency, may be invoked as a justification of torture.

3. An order from a superior officer or a public authority may not be invoked as a justification of torture.

Article 3

1. No State Party shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.

Article 4

1. Each State Party shall ensure that all acts of torture are offences under its criminal law. The same shall apply to an attempt to commit torture and to an act by any person which constitutes complicity or participation in torture.

2. Each State Party shall make these offences punishable by appropriate penalties which take into account their grave nature.

Article 5

1. Each State Party shall take such measures as may be necessary to establish its jurisdiction over the offences referred to in article 4 in the following cases:

   a. When the offences are committed in any territory under its jurisdiction or on board a ship or aircraft registered in that State;

   b. When the alleged offender is a national of that State;

   c. When the victim is a national of that State if that State considers it appropriate.

2. Each State Party shall likewise take such measures as may be necessary to establish its jurisdiction over such offences in cases where the alleged offender is present in any territory under its jurisdiction and it does not extradite him pursuant to article 8 to any of the States mentioned in paragraph I of this article.

3. This Convention does not exclude any criminal jurisdiction exercised in accordance with internal law.

Article 6

1. Upon being satisfied, after an examination of information available to it, that the circumstances so warrant, any State Party in whose territory a person alleged to have committed any offence referred to in article 4 is present shall take him into custody or take other legal measures to ensure his presence. The custody and other legal measures shall be as provided in the law of that State but may be continued only for such time as is necessary to enable any criminal or extradition proceedings to be instituted.

2. Such State shall immediately make a preliminary inquiry into the facts.

3. Any person in custody pursuant to paragraph 1 of this article shall be assisted in communicating immediately with the nearest appropriate representative of the State of which he is a national, or, if he is a stateless person, with the representative of the State where he usually resides.

4. When a State, pursuant to this article, has taken a person into custody, it shall immediately notify the States referred to in article 5, paragraph 1, of the fact that such person is in custody and of the circumstances which warrant his detention. The State which makes the preliminary inquiry contemplated in paragraph 2 of this article shall promptly report its findings to the said States and shall indicate whether it intends to exercise jurisdiction.

Article 7

1. The State Party in the territory under whose jurisdiction a person alleged to have committed any offence referred to in article 4 is found shall in the cases contemplated in article 5, if it does not extradite him, submit the case to its competent authorities for the purpose of prosecution.

2. These authorities shall take their decision in the same manner as in the case of any ordinary offence of a serious nature under the law of that State. In the cases referred to in article 5, paragraph 2, the standards of evidence required for prosecution and conviction shall in no way be less stringent than those which apply in the cases referred to in article 5, paragraph 1.

3. Any person regarding whom proceedings are brought in connection with any of the offences referred to in article 4 shall be guaranteed fair treatment at all stages of the proceedings.

Article 8

1. The offences referred to in article 4 shall be deemed to be included as extraditable offences in any extradition treaty existing between States Parties. States Parties undertake to include such offences as extraditable offences in every extradition treaty to be concluded between them.

2. If a State Party which makes extradition conditional on the existence of a treaty receives a request for extradition from another State Party with which it has no extradition treaty, it may consider this Convention as the legal basis for extradition in respect of such offences. Extradition shall be subject to the other conditions provided by the law of the requested State.

3. States Parties which do not make extradition conditional on the existence of a treaty shall recognize such offences as extraditable offences between themselves subject to the conditions provided by the law of the requested State.

4. Such offences shall be treated, for the purpose of extradition between States Parties, as if they had been committed not only in the place in which they occurred but also in the territories of the States required to establish their jurisdiction in accordance with article 5, paragraph 1.

Article 9

1. States Parties shall afford one another the greatest measure of assistance in connection with criminal proceedings brought in respect of any of the offences referred to in article 4, including the supply of all evidence at their disposal necessary for the proceedings.
2. States Parties shall carry out their obligations under paragraph I of this article in conformity with any treaties on mutual judicial assistance that may exist between them.

Article 10

1. Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.
2. Each State Party shall include this prohibition in the rules or instructions issued in regard to the duties and functions of any such person.

Article 11

Each State Party shall keep under systematic review interrogation rules, instructions, methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture.

Article 12

Each State Party shall ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.

Article 13

Each State Party shall ensure that any individual who alleges he has been subjected to torture in any territory under its jurisdiction has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. Steps shall be taken to ensure that the complainant and witnesses are protected against all ill-treatment or intimidation as a consequence of his complaint or any evidence given.

Article 14

1. Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.
2. Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

Article 15

Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made.

Article 16

1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.
2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion.

PART II

Article 17

1. There shall be established a Committee against Torture (hereinafter referred to as the Committee) which shall carry out the functions hereinafter provided. The Committee shall consist of ten experts of high moral standing and recognized competence in the field of human rights, who shall serve in their personal capacity. The experts shall be elected by the States Parties, consideration being given to equitable geographical distribution and to the usefulness of the participation of some persons having legal experience.
2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals. States Parties shall bear in mind the usefulness of nominating persons who are also members of the Human Rights Committee established under the International Covenant on Civil and Political Rights and who are willing to serve on the Committee against Torture.
3. Elections of the members of the Committee shall be held at biennial meetings of States Parties convened by the Secretary-General of the United Nations. At those meetings, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.
4. The initial election shall be held no later than six months after the date of the entry into force of this Convention. At. least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within three months. The Secretary-General shall prepare a list in alphabetical

order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.

5. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. However, the term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election the names of these five members shall be chosen by lot by the chairman of the meeting referred to in paragraph 3 of this article.

6. If a member of the Committee dies or resigns or for any other cause can no longer perform his Committee duties, the State Party which nominated him shall appoint another expert from among its nationals to serve for the remainder of his term, subject to the approval of the majority of the States Parties. The approval shall be considered given unless half or more of the States Parties respond negatively within six weeks after having been informed by the Secretary-General of the United Nations of the proposed appointment.

7. States Parties shall be responsible for the expenses of the members of the Committee while they are in performance of Committee duties. (amendment (see General Assembly resolution 47/111 of 16 December 1992);

Article 18

1. The Committee shall elect its officers for a term of two years. They may be re-elected.

2. The Committee shall establish its own rules of procedure, but these rules shall provide, inter alia, that:

   (a) Six members shall constitute a quorum;

   (b) Decisions of the Committee shall be made by a majority vote of the members present.

3. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under this Convention.

4. The Secretary-General of the United Nations shall convene the initial meeting of the Committee. After its initial meeting, the Committee shall meet at such times as shall be provided in its rules of procedure.

5. The States Parties shall be responsible for expenses incurred in connection with the holding of meetings of the States Parties and of the Committee, including reimbursement to the United Nations for any expenses, such as the cost of staff and facilities, incurred by the United Nations pursuant to paragraph 3 of this article. (amendment (see General Assembly resolution 47/111 of 16 December 1992);

Article 19

1. The States Parties shall submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have taken to give effect to their undertakings under this Convention, within one year after the entry into force of the Convention for the State Party

concerned. Thereafter the States Parties shall submit supplementary reports every four years on any new measures taken and such other reports as the Committee may request.

2. The Secretary-General of the United Nations shall transmit the reports to all States Parties.

3. Each report shall be considered by the Committee which may make such general comments on the report as it may consider appropriate and shall forward these to the State Party concerned. That State Party may respond with any observations it chooses to the Committee.

4. The Committee may, at its discretion, decide to include any comments made by it in accordance with paragraph 3 of this article, together with the observations thereon received from the State Party concerned, in its annual report made in accordance with article 24. If so requested by the State Party concerned, the Committee may also include a copy of the report submitted under paragraph I of this article.

Article 20

1. If the Committee receives reliable information which appears to it to contain well-founded indications that torture is being systematically practised in the territory of a State Party, the Committee shall invite that State Party to co-operate in the examination of the information and to this end to submit obselvations with regard to the information concerned.

2. Taking into account any observations which may have been submitted by the State Party concerned, as well as any other relevant information available to it, the Committee may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the Committee urgently.

3. If an inquiry is made in accordance with paragraph 2 of this article, the Committee shall seek the co-operation of the State Party concerned. In agreement with that State Party, such an inquiry may include a visit to its territory.

4. After examining the findings of its member or members submitted in accordance with paragraph 2 of this article, the Commission shall transmit these findings to the State Party concerned together with any comments or suggestions which seem appropriate in view of the situation.

5. All the proceedings of the Committee referred to in paragraphs I to 4 of th is article s hall be con fidential , and at all stages of the proceedings the co-operation of the State Party shall be sought. After such proceedings have been completed with regard to an inquiry made in accordance with paragraph 2, the Committee may, after consultations with the State Party concerned, decide to include a summary account of the results of the proceedings in its annual report made in accordance with article 24.

Article 21

1. A State Party to this Convention may at any time declare under this article that it recognizes the competence of the Committee to receive and consider communications to the effect that a State Party claims that another State Party is not fulfilling its obligations under this Convention. Such communications may be received and considered according to the procedures laid down

in this article only if submitted by a State Party which has made a declaration recognizing in regard to itself the competence of the Committee. No communication shall be dealt with by the Committee under this article if it concerns a State Party which has not made such a declaration. Communications received under this article shall be dealt with in accordance with the following procedure;

a. If a State Party considers that another State Party is not giving effect to the provisions of this Convention, it may, by written communication, bring the matter to the attention of that State Party. Within three months afler the receipt of the communication the receiving State shall afford the State which sent the communication an explanation or any other statement in writing clarifying the matter, which should include, to the extent possible and pertinent, reference to domestic procedures and remedies taken, pending or available in the matter;

b. If the matter is not adjusted to the satisfaction of both States Parties concerned within six months after the receipt by the receiving State of the initial communication, either State shall have the right to refer the matter to the Committee, by notice given to the Committee and to the other State;

c. The Committee shall deal with a matter referred to it under this article only after it has ascertained that all domestic remedies have been invoked and exhausted in the matter, in conformity with the generally recognized principles of international law. This shall not be the rule where the application of the remedies is unreasonably prolonged or is unlikely to bring effective relief to the person who is the victim of the violation of this Convention;

d. The Committee shall hold closed meetings when examining communications under this article;

e. Subject to the provisions of subparagraph (c), the Committee shall make available its good offices to the States Parties concerned with a view to a friendly solution of the matter on the basis of respect for the obligations provided for in this Convention. For this purpose, the Committee may, when appropriate, set up an ad hoc conciliation commission;

f. In any matter referred to it under this article, the Committee may call upon the States Parties concerned, referred to in subparagraph (b), to supply any relevant information;

g. The States Parties concerned, referred to in subparagraph (b), shall have the right to be represented when the matter is being considered by the Committee and to make submissions orally and/or in writing;

h. The Committee shall, within twelve months after the date of receipt of notice under subparagraph (b), submit a report:

   (i) If a solution within the terms of subparagraph (e) is reached, the Committee shall confine its report to a brief statement of the facts and of the solution reached;

   (ii) If a solution within the terms of subparagraph (e) is not reached, the Committee shall confine its report to a brief statement of the facts; the written submissions and record

of the oral submissions made by the States Parties concerned shall be attached to the report.

In every matter, the report shall be communicated to the States Parties concerned.

2. The provisions of this article shall come into force when five States Parties to this Convention have made declarations under paragraph 1 of this article. Such declarations shall be deposited by the States Parties with the Secretary-General of the United Nations, who shall transmit copies thereof to the other States Parties. A declaration may be withdrawn at any time by notification to the Secretary-General. Such a withdrawal shall not prejudice the consideration of any matter which is the subject of a communication already transmitted under this article; no further communication by any State Party shall be received under this article after the notification of withdrawal of the declaration has been received by the Secretary-General, unless the State Party concerned has made a new declaration.

Article 22

1. A State Party to this Convention may at any time declare under this article that it recognizes the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State Party of the provisions of the Convention. No communication shall be received by the Committee if it concerns a State Party which has not made such a declaration.

2. The Committee shall consider inadmissible any communication under this article which is anonymous or which it considers to be an abuse of the right of submission of such communications or to be incompatible with the provisions of this Convention.

3. Subject to the provisions of paragraph 2, the Committee shall bring any communications submitted to it under this article to the attention of the State Party to this Convention which has made a declaration under paragraph I and is alleged to be violating any provisions of the Convention. Within six months, the receiving State shall submit to the Committee written explanations or statements clarifying the matter and the remedy, if any, that may have been taken by that State.

4. The Committee shall consider communications received under this article in the light of all information made available to it by or on behalf of the individual and by the State Party concerned.

6. The Committee shall not consider any communications from an individual under this article unless it has ascertained that:

   (a) The same matter has not been, and is not being, examined under another procedure of international investigation or settlement;

   (b) The individual has exhausted all available domestic remedies; this shall not be the rule where the application of the remedies is unreasonably prolonged or is unlikely to bring effective reliefto the person who is the victim of the violation of this Convention.

6. The Committee shall hold closed meetings when examining communications under this article.

7. The Committee shall forward its views to the State Party concerned and to the individual.

8. The provisions of this article shall come into force when five States Parties to this Convention have made declarations under paragraph 1 of this article. Such declarations shall be deposited by the States Parties with the Secretary-General of the United Nations, who shall transmit copies thereof to the other States Parties. A declaration may be withdrawn at any time by notification to the Secretary-General. Such a withdrawal shall not prejudice the consideration of any matter which is the subject of a communication already transmitted under this article; no further communication by or on behalf of an individual shall be received under this article after the notification of withdrawal of the declaration has been received by the SecretaryGeneral, unless the State Party has made a new declaration.

Article 23

The members of the Committee and of the ad hoc conciliation commissions which may be appointed under article 21, paragraph I (e), shall be entitled to the facilities, privileges and immunities of experts on mission for the United Nations as laid down in the relevant sections of the Convention on the Privileges and Immunities of the United Nations.

Article 24

The Committee shall submit an annual report on its activities under this Convention to the States Parties and to the General Assembly of the United Nations.

PART III

Article 25

1. This Convention is open for signature by all States. 2. This Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 26

This Convention is open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary General of the United Nations.

Article 27

1. This Convention shall enter into force on the thirtieth day after the date of the deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying this Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

Article 28

1. Each State may, at the time of signature or ratification of this Convention or accession thereto, declare that it does not recognize the competence of the Committee provided for in article 20.

2. Any State Party having made a reservation in accordance with paragraph I of this article may, at any time, withdraw this reservation by notification to the Secretary-General of the United Nations.

Article 29

1. Any State Party to this Convention may propose an amendment and file it with the Secretary-General of the United Nations. The SecretaryGeneral shall thereupon communicate the proposed amendment to the States Parties with a request that they notify him whether they favour a conference of States Parties for the purpose of considering an d voting upon the proposal. In the event that within four months from the date of such communication at least one third of the States Parties favours such a conference, the Secretary General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted by the Secretary-General to all the States Parties for acceptance.

2. An amendment adopted in accordance with paragraph I of this article shall enter into force when two thirds of the States Parties to this Convention have notified the Secretary-General of the United Nations that they have accepted it in accordance with their respective constitutional processes.

3. When amendments enter into force, they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of this Convention and any earlier amendments which they have accepted.

Article 30

1. Any dispute between two or more States Parties concerning the interpretation or application of this Convention which cannot be settled through negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from thc date of the request for arbitration the Parties are unable to agree on the organization of the arbitration, any one of those Parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.

2. Each State may, at the time of signature or ratification of this Con vention or accession thereto, declare that it does not consider itself bound by paragraph I of this article. The other States Parties shall not be bound by paragraph I of this article with respect to any State Party having made such a reservation.

3. Any State Party having made a reservation in accordance with paragraph 2 of this article may at any time withdraw this reservation by notification to the Secretary-General of the United Nations.

Article 31

1. A State Party may denounce this Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of- the notification by the Secretary-General .

2. Such a denunciation shall not have the effect of releasing the State Party from its obligations under this Convention in regard to any act or omission which occurs prior to the date at which the denunciation becomes effective, nor shall denunciation prejudice in any way the continued consideration of any matter which is already under consideration by the Committee prior to the date at which the denunciation becomes effective.

3. Following the date at which the denunciation of a State Party becomes effective, the Committee shall not commence consideration of any new matter regarding that State.

Article 32

The Secretary-General of the United Nations shall inform all States Members of the United Nations and all States which have signed this Convention or acceded to it of the following:

a. Signatures, ratifications and accessions under articles 25 and 26;

b. The date of entry into force of this Convention under article 27 and the date of the entry into force of any amendments under article 29;

c. Denunciations under article 31.

Article 33

1. This Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of this Convention to all States.

23. Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

PREAMBLE

The States Parties to the present Protocol,

Reaffirming that torture and other cruel, inhuman or degrading treatment or punishment are prohibited and constitute serious violations of human rights,

Convinced that further measures are necessary to achieve the purposes of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereinafter referred to as the Convention) and to strengthen the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment,

Recalling that articles 2 and 16 of the Convention oblige each State Party to take effective measures to prevent acts of torture and other cruel, inhuman or degrading treatment or punishment in any territory under its jurisdiction,

Recognizing that States have the primary responsibility for implementing those articles, that strengthening the protection of people deprived of their liberty and the full respect for their human

rights is a common responsibility shared by all and that international implementing bodies complement and strengthen national measures,

Recalling that the effective prevention of torture and other cruel, inhuman or degrading treatment or punishment requires education and a combination of various legislative, administrative, judicial and other measures,

Recalling also that the World Conference on Human Rights firmly declared that efforts to eradicate torture should first and foremost be concentrated on prevention and called for the adoption of an optional protocol to the Convention, intended to establish a preventive system of regular visits to places of detention,

Convinced that the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment can be strengthened by non-judicial means of a preventive nature, based on regular visits to places of detention,

Have agreed as follows:

PART I

General principles

Article 1

The objective of the present Protocol is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

Article 2

1. A Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of the Committee against Torture (hereinafter referred to as the Subcommittee on Prevention) shall be established and shall carry out the functions laid down in the present Protocol.

2. The Subcommittee on Prevention shall carry out its work within the framework of the Charter of the United Nations and shall be guided by the purposes and principles thereof, as well as the norms of the United Nations concerning the treatment of people deprived of their liberty.

3. Equally, the Subcommittee on Prevention shall be guided by the principles of confidentiality, impartiality, non-selectivity, universality and objectivity.

4. The Subcommittee on Prevention and the States Parties shall cooperate in the implementation of the present Protocol.

Article 3

Each State Party shall set up, designate or maintain at the domestic level one or several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter referred to as the national preventive mechanism).

Article 4

1. Each State Party shall allow visits, in accordance with the present Protocol, by the mechanisms referred to in articles 2 and 3 to any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (hereinafter referred to as places of detention). These visits shall be undertaken with a view to strengthening, if necessary, the protection of these persons against torture and other cruel, inhuman or degrading treatment or punishment.

2. For the purposes of the present Protocol, deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.

PART II

Subcommittee on Prevention

Article 5

1. The Subcommittee on Prevention shall consist of ten members. After the fiftieth ratification of or accession to the present Protocol, the number of the members of the Subcommittee on Prevention shall increase to twenty-five.
2. The members of the Subcommittee on Prevention shall be chosen from among persons of high moral character, having proven professional experience in the field of the administration of justice, in particular criminal law, prison or police administration, or in the various fields relevant to the treatment of persons deprived of their liberty.
3. In the composition of the Subcommittee on Prevention due consideration shall be given to equitable geographic distribution and to the representation of different forms of civilization and legal systems of the States Parties.
4. In this composition consideration shall also be given to balanced gender representation on the basis of the principles of equality and non-discrimination.
5. No two members of the Subcommittee on Prevention may be nationals of the same State.
6. The members of the Subcommittee on Prevention shall serve in their individual capacity, shall be independent and impartial and shall be available to serve the Subcommittee on Prevention efficiently.

Article 6

1. Each State Party may nominate, in accordance with paragraph 2 of the present article, up to two candidates possessing the qualifications and meeting the requirements set out in article 5, and in doing so shall provide detailed information on the qualifications of the nominees.

2. (a) The nominees shall have the nationality of a State Party to the present Protocol;

(b) At least one of the two candidates shall have the nationality of the nominating State Party;

(c) No more than two nationals of a State Party shall be nominated;

(d) Before a State Party nominates a national of another State Party, it shall seek and obtain the consent of that State Party.

3. At least five months before the date of the meeting of the States Parties during which the elections will be held, the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within three months. The Secretary-General shall submit a list, in alphabetical order, of all persons thus nominated, indicating the States Parties that have nominated them.

Article 7

1. The members of the Subcommittee on Prevention shall be elected in the following manner:

(a) Primary consideration shall be given to the fulfilment of the requirements and criteria of article 5 of the present Protocol;

(b) The initial election shall be held no later than six months after the entry into force of the present Protocol;

(c) The States Parties shall elect the members of the Subcommittee on Prevention by secret ballot;

(d) Elections of the members of the Subcommittee on Prevention shall be held at biennial meetings of the States Parties convened by the Secretary - General of the United Nations. At those meetings, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Subcommittee on Prevention shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of the States Parties present and voting.

2. If during the election process two nationals of a State Party have become eligible to serve as members of the Subcommittee on Prevention, the candidate receiving the higher number of votes shall serve as the member of the Subcommittee on Prevention. Where nationals have received the same number of votes, the following procedure applies:

(a) Where only one has been nominated by the State Party of which he or she is a national, that national shall serve as the member of the Subcommittee on Prevention;

(b) Where both candidates have been nominated by the State Party of which they are nationals, a separate vote by secret ballot shall be held to determine which national shall become the member;

(c) Where neither candidate has been nominated by the State Party of which he or she is a national, a separate vote by secret ballot shall be held to determine which candidate shall be the member.

Article 8

If a member of the Subcommittee on Prevention dies or resigns, or for any cause can no longer perform his or her duties, the State Party that nominated the member shall nominate another eligible person possessing the qualifications and meeting the requirements set out in article 5,

taking into account the need for a proper balance among the various fields of competence, to serve until the next meeting of the States Parties, subject to the approval of the majority of the States Parties. The approval shall be considered given unless half or more of the States Parties respond negatively within six weeks after having been informed by the Secretary-General of the United Nations of the proposed appointment.

Article 9

The members of the Subcommittee on Prevention shall be elected for a term of four years. They shall be eligible for re-election once if renominated. The term of half the members elected at the first election shall expire at the end of two years; immediately after the first election the names of those members shall be chosen by lot by the Chairman of the meeting referred to in article 7, paragraph 1 (d).

Article 10

1. The Subcommittee on Prevention shall elect its officers for a term of two years. They may be re-elected.

2. The Subcommittee on Prevention shall establish its own rules of procedure. These rules shall provide, inter alia, that:

(a) Half the members plus one shall constitute a quorum;

(b) Decisions of the Subcommittee on Prevention shall be made by a majority vote of the members present;

(c) The Subcommittee on Prevention shall meet in camera.

3. The Secretary-General of the United Nations shall convene the initial meeting of the Subcommittee on Prevention. After its initial meeting, the Subcommittee on Prevention shall meet at such times as shall be provided by its rules of procedure. The Subcommittee on Prevention and the Committee against Torture shall hold their sessions simultaneously at least once a year.

PART III

Mandate of the Subcommittee on Prevention

Article 11

The Subcommittee on Prevention shall:

(a) Visit the places referred to in article 4 and make recommendations to States Parties concerning the protection of persons deprived of their liberty against t[illegible] and other cruel, inhuman or degrading treatment or punishment;

(b) In regard to the national preventive mechanisms:

(i) Advise and assist States Parties, when necessary, in their establishment;

(ii) Maintain direct, and if necessary confidential, contact with the national preventive mechanisms and offer them training and technical assistance with a view to strengthening their capacities;

(iii) Advise and assist them in the evaluation of the needs and the means necessary to strengthen the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment;

(iv) Make recommendations and observations to the States Parties with a view to strengthening the capacity and the mandate of the national preventive mechanisms for the prevention of torture and other cruel, inhuman or degrading treatment or punishment;

(c) Cooperate, for the prevention of torture in general, with the relevant United Nations organs and mechanisms as well as with the international, regional and national institutions or organizations working towards the strengthening of the protection of all persons against torture and other cruel, inhuman or degrading treatment or punishment.

Article 12

In order to enable the Subcommittee on Prevention to comply with its mandate as laid down in article 11, the States Parties undertake:

(a) To receive the Subcommittee on Prevention in their territory and grant it access to the places of detention as defined in article 4 of the present Protocol;

(b) To provide all relevant information the Subcommittee on Prevention may request to evaluate the needs and measures that should be adopted to strengthen the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment;

(c) To encourage and facilitate contacts between the Subcommittee on Prevention and the national preventive mechanisms;

(d) To examine the recommendations of the Subcommittee on Prevention and enter into dialogue with it on possible implementation measures.

Article 13

1. The Subcommittee on Prevention shall establish, at first by lot, a programme of regular visits to the States Parties in order to fulfil its mandate as established in article 11.

2. After consultations, the Subcommittee on Prevention shall notify the States Parties of its programme in order that they may, without delay, make the necessary practical arrangements for the visits to be conducted.

3. The visits shall be conducted by at least two members of the Subcommittee on Prevention. These members may be accompanied, if needed, by experts of demonstrated professional experience and knowledge in the fields covered by the present Protocol who shall be selected from a roster of experts prepared on the basis of proposals made by the States Parties, the Office of the United Nations High Commissioner for Human Rights and the United Nations Centre for International Crime Prevention. In preparing the roster, the States Parties concerned shall propose no more than five national experts. The State Party concerned may oppose the inclusion of a specific expert in the visit, whereupon the Subcommittee on Prevention shall propose another expert.

4. If the Subcommittee on Prevention considers it appropriate, it may propose a short follow-up visit after a regular visit.

Article 14

1. In order to enable the Subcommittee on Prevention to fulfil its mandate, the States Parties to the present Protocol undertake to grant it:

(a) Unrestricted access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location;

(b) Unrestricted access to all information referring to the treatment of those persons as well as their conditions of detention;

(c) Subject to paragraph 2 below, unrestricted access to all places of detention and their installations and facilities;

(d) The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the Subcommittee on Prevention believes may supply relevant information;

(e) The liberty to choose the places it wants to visit and the persons it wants to interview.

2. Objection to a visit to a particular place of detention may be made only on urgent and compelling grounds of national defence, public safety, natural disaster or serious disorder in the place to be visited that temporarily prevent the carrying out of such a visit. The existence of a declared state of emergency as such shall not be invoked by a State Party as a reason to object to a visit.

Article 15

No authority or official shall order, apply, permit or tolerate any sanction against any person or organization for having communicated to the Subcommittee on Prevention or to its delegates any information, whether true or false, and no such person or organization shall be otherwise prejudiced in any way.

Article 16

1. The Subcommittee on Prevention shall communicate its recommendations and observations confidentially to the State Party and, if relevant, to the national preventive mechanism.

2. The Subcommittee on Prevention shall publish its report, together with any comments of the State Party concerned, whenever requested to do so by that State Party. If the State Party makes part of the report public, the Subcommittee on Prevention may publish the report in whole or in part. However, no personal data shall be published without the express consent of the person concerned.

3. The Subcommittee on Prevention shall present a public annual report on its activities to the Committee against Torture.

4. If the State Party refuses to cooperate with the Subcommittee on Prevention according to articles 12 and 14, or to take steps to improve the situation in the light of the recommendations of the Subcommittee on Prevention, the Committee against Torture may, at the request of the Subcommittee on Prevention, decide, by a majority of its members, after the State Party has had an opportunity to make its views known, to make a public statement on the matter or to publish the report of the Subcommittee on Prevention.

PART IV

National preventive mechanisms

Article 17

Each State Party shall maintain, designate or establish, at the latest one year after the entry into force of the present Protocol or of its ratification or accession, one or several independent national preventive mechanisms for the prevention of torture at the domestic level. Mechanisms established by decentralized units may be designated as national preventive mechanisms for the purposes of the present Protocol if they are in conformity with its provisions.

Article 18

1. The States Parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel.

2. The States Parties shall take the necessary measures to ens ure that the experts of the national preventive mechanism have the required capabilities and professional knowledge. They shall strive for a gender balance and the adequate representation of ethnic and minority groups in the country.

3. The States Parties undertake to make available the necessary resources for the functioning of the national preventive mechanisms.

4. When establishing national preventive mechanisms, States Parties shall give due consideration to the Principles relating to the status of national institutions for the promotion and protection of human rights.

Article 19

The national preventive mechanisms shall be granted at a minimum the power:

(a) To regularly examine the treatment of the persons deprived of their liberty in places of detention as defined in article 4, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment;

(b) To make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture and other cruel,

inhuman or degrading treatment or punishment, taking into consideration the relevant norms of the United Nations;

(c) To submit proposals and observations concerning existing or draft legislation.

Article 20

In order to enable the national preventive mechanisms to fulfil their mandate, the States Parties to the present Protocol undertake to grant them:

(a) Access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location;

(b) Access to all information referring to the treatment of those persons as well as their conditions of detention;

(c) Access to all places of detention and their installations and facilities;

(d) The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the national preventive mechanism believes may supply relevant information;

(e) The liberty to choose the places they want to visit and the persons they want to interview;

(f) The right to have contacts with the Subcommittee on Prevention, to send it information and to meet with it.

Article 21

1. No authority or official shall order, apply, permit or tolerate any sanction against any person or organization for having communicated to the national preventive mechanism any information, whether true or false, and no such person or organization shall be otherwise prejudiced in any way.

2. Confidential information collected by the national preventive mechanism shall be privileged. No personal data shall be published without the express consent of the person concerned.

Article 22

The competent authorities of the State Party concerned shall examine the recommendations of the national preventive mechanism and enter into a dialogue with it on possible implementation measures.

Article 23

The States Parties to the present Protocol undertake to publish and disseminate the annual reports of the national preventive mechanisms.

PART V

Declaration

Article 24

1. Upon ratification, States Parties may make a declaration postponing the implementation of their obligations under either part III or part IV of the present Protocol.

2. This postponement shall be valid for a maximum of three years. After due representations made by the State Party and after consultation with the Subcommittee on Pre vention, the Committee against Torture may extend that period for an additional two years.

PART VI

Financial provisions

Article 25

1. The expenditure incurred by the Subcommittee on Prevention in the implementation of the present Protocol shall be borne by the United Nations.

2. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Subcommittee on Prevention under the present Protocol.

Article 26

1. A Special Fund shall be set up in accordance with the relevant procedures of the General Assembly, to be administered in accordance with the financial regulations and rules of the United Nations, to help finance the implementation of the recommendations made by the Subcommittee on Prevention after a visit to a State Party, as well as education programmes of the national preventive mechanisms.

2. The Special Fund may be financed through voluntary contributions made by Governments, intergovernmental and non-governmental organizations and other private or public entities.

PART VII

Final provisions

Article 27

1. The present Protocol is open for signature by any State that has signed the Convention.

2. The present Protocol is subject to ratification by any State that has ratified or acceded to the Convention. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

3. The present Protocol shall be open to accession by any State that has ratified or acceded to the Convention.

4. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

5. The Secretary-General of the United Nations shall inform all States that have signed the present Protocol or acceded to it of the deposit of each instrument of ratification or accession.

Article 28

1. The present Protocol shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying the present Protocol or acceding to it after the deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession, the present Protocol shall enter into force on the thirtieth day after the date of deposit of its own instrument of ratification or accession.

Article 29

The provisions of the present Protocol shall extend to all parts of federal States without any limitations or exceptions.

Article 30

No reservations shall be made to the present Protocol.

Article 31

The provisions of the present Protocol shall not affect the obligations of States Parties under any regional convention instituting a system of visits to places of detention. The Subcommittee on Prevention and the bodies established under such regional conventions are encouraged to consult and cooperate with a view to avoiding duplication and promoting effectively the objectives of the present Protocol.

Article 32

The provisions of the present Protocol shall not affect the obligations of States Parties to the four Geneva Conventions of 12 August 1949 and the Additional Protocols thereto of 8 June 1977, nor the opportunity available to any State Party to authorize the International Committee of the Red Cross to visit places of detention in situations not covered by international humanitarian law.

Article 33

1. Any State Party may denounce the present Protocol at any time by written notification addressed to the Secretary-General of the United Nations, who shall thereafter inform the other States Parties to the present Protocol and the Convention. Denunciation shall take effect one year after the date of receipt of the notification by the Secretary-General.

2. Such a denunciation shall not have the effect of releasing the St ate Party from its obligations under the present Protocol in regard to any act or situation that may occur prior to the date on which the denunciation becomes effective, or to the actions that the Subcommittee on Prevention has decided or may decide to take with respect to the State Party concerned, nor shall denunciation prejudice in any way the continued consideration of any matter already under consideration by the Subcommittee on Prevention prior to the date on which the denunciation becomes effective.

3. Following the date on which the denunciation of the State Party becomes effective, the Subcommittee on Prevention shall not commenceconsideration of any new matter regarding that State.

Article 34

1. Any State Party to the present Protocol may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to the States Parties to the present Protocol with a request that they notify him whether they favour a conference of States Parties for the purpose of considering and voting upon the proposal. In the event that within four months from the date of such communication at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of two thirds of the States Parties present and voting at the conference shall be submitted by the Secretary-General of the United Nations to all States Parties for acceptance.

2. An amendment adopted in accordance with paragraph 1 of the present article shall come into force when it has been accepted by a two -thirds majority of the States Parties to the present Protocol in accordance with their respective constitutional processes.

3. When amendments come into force, they shall be binding on those States Parties that have accepted them, other States Parties still being bound by the provisions of the present Protocol and any earlier amendment that they have accepted.

Article 35

Members of the Subcommittee on Prevention and of the national preventive mechanisms shall be accorded such privileges and immunities as are necessary for the independent exercise of their functions. Members of the Subcommittee on Prevention shall be accorded the privileges and immunities specified in section 22 of the Convention on the Privileges and Immunities of the United Nations of 13 February 1946, subject to the provisions of section 23 of that Convention.

Article 36

When visiting a State Party, the members of the Subcommittee on Prevention shall, without prejudice to the provisions and purposes of the present Protocol and such privileges and immunities as they may enjoy:

(a) Respect the laws and regulations of the visited State;

(b) Refrain from any action or activity incompatible with the impartial and international nature of their duties.

Article 37

1. The present Protocol, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be de posited with the Secretary-General of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of the present Protocol to all States.

24. Basic Principles for the Treatment of Prisoners

Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990

1. All prisoners shall be treated with the respect due to their inherent dignity and value as human beings.
2. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. It is, however, desirable to respect the religious beliefs and cultural precepts of the group to which prisoners belong, whenever local conditions so require.
4. The responsibility of prisons for the custody of prisoners and for the protection of society against crime shall be discharged in keeping with a State's other social objectives and its fundamental responsibilities for promoting the well-being and development of all members of society.
5. Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants.
6. All prisoners shall have the right to take part in cultural activities and education aimed at the full development of the human personality.
7. Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged.
8. Conditions shall be created enabling prisoners to undertake meaningful remunerated employment which will facilitate their reintegration into the country's labour market and permit them to contribute to their own financial support and to that of their families.
9. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.
10. With the participation and help of the community and social institutions, and with due regard to the interests of victims, favourable conditions shall be created for the reintegration of the ex-prisoner into society under the best possible conditions.
11. The above Principles shall be applied impartially.

25. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power

Adopted by General Assembly resolution 40/34 of 29 November 1985

A. Victims of Crime

1. "Victims" means persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws operative within Member States, including those laws proscribing criminal abuse of power.

2. A person may be considered a victim, under this Declaration, regardless of whether the perpetrator is identified, apprehended, prosecuted or convicted and regardless of the familial relationship between the perpetrator and the victim. The term "victim" also includes, where appropriate, the immediate family or dependants of the direct victim and persons who have suffered harm in intervening to assist victims in distress or to prevent victimization.

3. The provisions contained herein shall be applicable to all, without distinction of any kind, such as race, colour, sex, age, language, religion, nationality, political or other opinion, cultural beliefs or practices, property, birth or family status, ethnic or social origin, and disability.

Access to justice and fair treatment

4. Victims should be treated with compassion and respect for their dignity. They are entitled to access to the mechanisms of justice and to prompt redress, as provided for by national legislation, for the harm that they have suffered.

5. Judicial and administrative mechanisms should be established and strengthened where necessary to enable victims to obtain redress through formal or informal procedures that are expeditious, fair, inexpensive and accessible. Victims should be informed of their rights in seeking redress through such mechanisms.

6. The responsiveness of judicial and administrative processes to the needs of victims should be facilitated by:

(a) Informing victims of their role and the scope, timing and progress of the proceedings and of the disposition of their cases, especially where serious crimes are involved and where they have requested such information;

(b) Allowing the views and concerns of victims to be presented and considered at appropriate stages of the proceedings where their personal interests are affected, without prejudice to the accused and consistent with the relevant national criminal justice system;

(c) Providing proper assistance to victims throughout the legal process;

(d) Taking measures to minimize inconvenience to victims, protect their privacy, when necessary, and ensure their safety, as well as that of their families and witnesses on their behalf, from intimidation and retaliation;

(e) Avoiding unnecessary delay in the disposition of cases and the execution of orders or decrees granting awards to victims.

7. Informal mechanisms for the resolution of disputes, including mediation, arbitration and customary justice or indigenous practices, should be utilized where appropriate to facilitate conciliation and redress for victims.

Restitution

8. Offenders or third parties responsible for their behaviour should, where appropriate, make fair restitution to victims, their families or dependants. Such restitution should include the return of property or payment for the harm or loss suffered, reimbursement of expenses incurred as a result of the victimization, the provision of services and the restoration of rights.

9. Governments should review their practices, regulations and laws to consider restitution as an available sentencing option in criminal cases, in addition to other criminal sanctions.

10. In cases of substantial harm to the environment, restitution, if ordered, should include, as far as possible, restoration of the environment, reconstruction of the infrastructure, replacement of community facilities and reimbursement of the expenses of relocation, whenever such harm results in the dislocation of a community.

11. Where public officials or other agents acting in an official or quasi-official capacity have violated national criminal laws, the victims should receive restitution from the State whose officials or agents were responsible for the harm inflicted. In cases where the Government under whose authority the victimizing act or omission occurred is no longer in existence, the State or Government successor in title should provide restitution to the victims.

Compensation

12. When compensation is not fully available from the offender or other sources, States should endeavour to provide financial compensation to:

(a) Victims who have sustained significant bodily injury or impairment of physical or mental health as a result of serious crimes;

(b) The family, in particular dependants of persons who have died or become physically or mentally incapacitated as a result of such victimization.

13. The establishment, strengthening and expansion of national funds for compensation to victims should be encouraged. Where appropriate, other funds may also be established for this purpose, including in those cases where the State of which the victim is a national is not in a position to compensate the victim for the harm.

Assistance

14. Victims should receive the necessary material, medical, psychological and social assistance through governmental, voluntary, community-based and indigenous means.

15. Victims should be informed of the availability of health and social services and other relevant assistance and be readily afforded access to them.

16. Police, justice, health, social service and other personnel concerned should receive training to sensitize them to the needs of victims, and guidelines to ensure proper and prompt aid.

17. In providing services and assistance to victims, attention should be given to those who have special needs because of the nature of the harm inflicted or because of factors such as those mentioned in paragraph 3 above.

B. Victims of Abuse of Power

18. "Victims" means persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that do not yet constitute violations of national criminal laws but of internationally recognized norms relating to human rights.

19. States should consider incorporating into the national law norms proscribing abuses of power and providing remedies to victims of such abuses. In particular, such remedies should include restitution and/or compensation, and necessary material, medical, psychological and social assistance and support.

20. States should consider negotiating multilateral international treaties relating to victims, as defined in paragraph 18.

21. States should periodically review existing legislation and practices to ensure their responsiveness to changing circumstances, should enact and enforce, if necessary, legislation proscribing acts that constitute serious abuses of political or economic power, as well as promoting policies and mechanisms for the prevention of such acts, and should develop and make readily available appropriate rights and remedies for victims of such acts.

26. Format for filing a complaint with the NHRC

A. COMPLAINANT'S DETAILS

1. Name

3. State

2. Sex Male Female

4. Full Address

5. District

6. Pin Code

B. INCIDENT DETAILS

1. Incident Place(Village/Town/City)

2. State

3. District

4. Date of Incident

C. VICTIM'S DETAILS

1. Name of the victim

3.State

2. No. of victims

4. Full Address

5.District

6.Pin Code

7. Religion

8.Caste (SC/ST/OBC/General)

9. Sex

10. Age

11.Whether Disabled person

Contd.....

D. Brief summary of facts/allegations of human rights involved

E. Whether complaint is against Members of Armed Forces / Para-Military

Yes ☐ No ☐

F. Whether similar complaint has been filed before any Court/ State Human Rights Commission

G. Name, designation & address of the public servant against whom Complaint is being made

H. Name, designation & address of the authority/officials to whom the public servant is answerable

I. Prayer/ Relief if any, sought

Guidelines on how to file complaint with the NHRC

1. Complaint may be made to the Commission by the victim or any other person on his behalf.
2. Complaint should be in writing either in English or Hindi or in any other language included in the eighth schedule of the Constitution. Only one set of complaint needs to be submitted to the Commission.
3. Complaint may be sent either by Post or Faxed at Nos. 91-11-23382911/ 23382734 or through e-mail **covdnhrc@nic.in**
4. No fee is chargeable on such complaints.
5. The complaint shall disclose i) violation of human rights or abetment thereof or; (ii) negligence in the prevention of such violations, by a public servant.
6. The jurisdiction of the Commission is restricted to the violation of human rights alleged to have been committed within one year of the receipt of complaint by the Commission.
7. Documents, if any enclosed in support of the allegations in the complaint must be legible.
8. Name of the victim, his/ her age, sex, religion/ caste, State and District to which the incident relates, incident date etc. should invariably be mentioned in the complaint.
9. Please submit the complaint preferably in the enclosed format.
10. Following types of Complaint(s) are not ordinarily entertainable:
    i. Illegible
    ii. Vague, anonymous or pseudonymous;
    iii. Trivial or frivolous in nature;
    iv. The matters which are pending before a State Human Rights Commission or any other Commission;
    v. Any matter after the expiry of one year from the date on which the act constituting violation of human rights is alleged to have been committed;
    vi. Allegation is not against any public servant;
    vii. The issue raised relates to civil dispute, such property rights, contractual obligations, etc;
    viii. The issue raised relates to service matters;
    ix. The issue raised relates to labour/industrial disputes;
    x. Allegations do not make out any specific violation of human rights;
    xi. The matter is sub-judice before a Court/ Tribunal;
    xii. The matter is covered by judicial verdict/decision of the Commission.
11. As far as possible complainants are encouraged to make use of the format given above to file their complaints. The guidelines indicate the kind of information, which would facilitate in processing a complaint.

27. Contact Details

1. National Human Rights Institutions

National Human Rights Commission (NHRC) Faridkot House, Copernicus Marg, New Delhi-110001, Ph: 011 – 23382747 Fax No: 011 – 23384863(Admn) 23386521(Law) For Complaints-filing /status, General queries MADAD : 91-11-23385368 Mobile: +919810298900 E.Mail: nhrc@ren.nic.in Website: www.nhrc.nic.in	**National Commission for Women (NCW)** 4, Deen Dayal Upadhayaya Marg, New Delhi-110 002. Ph: 91-11-23237166, 91-11-23236988 Fax : 91-11-23236154 Complaints Cell : 91-11-23219750 Email :ncw@nic.in Website : www.ncw.nic.in
National Commission for Scheduled Castes (NCSC) 5th Block, 11th Floor, Lok Nayak Bhavan, New Delhi -110 003. Phone No : +91-11 – 24635722,24625378 Fax No: +91-11 – 24625378 E-Mail: jointsecretary-ncsc@nic.in Website: www.ncsc.nic.in	**National Commission for Scheduled Tribes (NCST)** 6th Floor, Lok Nayak Bhavan, Khan Market, New Delhi -110 003. Ph: 180011777(Toll Free), +91-11 – 24620969 Website: www.ncst.nic.in
National Commission for Minorities (NCM) 5th Floor, Lok Nayak Bhavan, Khan Market, New Delhi -110 003 Fax : +91-11-24693302, 24642645, 24698410 E-Mail: ncm-mma@nic.in Website: www.ncm.nic.in	**National Commission for Backward Classes (NCBC)** TRIKOOT-1, Bhikaji Cama Place, New Delhi -110 066 Ph : +91-11-26189210-12 Fax : +91-11-26183227 E-Mail: dir-ncbc@nic.in, cbious-ncbc@nic.in Website: www.ncbc.nic.in

2. State Human Rights Institutions

Andhra Pradesh The Chairperson "Gruhakalpa", M.J. Road, Hyderabad-500001, E-Mail: aphumanrights@ap.nic.in. Tele(o):24601571, Fax:24601573, E-Mail:aphumanrights@ap.nic.in.	**Assam** The Chairperson, Statfed H.O Building, GMC Road, Bhangagarh, Guwahati - 781005 Ph: +91-361 - 2452387(O), 2360426 (R) Fax: +91-361 - 2529450/2527076 E-Mail: hrca@sancharnet.in
Chhatisgarh The Chairperson Near Mantralaya, Raipur-492001. STD: 0771, Fax: 2235590, E-Mail: cghrcryp@sify.com.	**Gujarat** Home Deptt., Govt. of Gujrat, Near Town Hall Sec-17, Gandhi nagar-382017 Ph: +91-79-23257546

Himachal Pradesh The Chairperson Pines grove Building, Shimla-171002, Fax: 0177- 224908.	**Jammu&Kashmir** The Chairperson Dawn building, Dalgate, Srinagar-119001. STD: 0194, Fax: 454046, Tele(o):2481802, 2454046, Fax:2454046.
Karnataka Shri Venkataramana Niwas, No. 399, 4th Cross, Second Block, Second State Rajmahal Vilas Extension, Bangalore-560094.	**Kerala** The Chairperson M.P. Appan Road, Vazhuthacaud, Thiruvananthapuram-695014 Tele(o): 0471-2337145 Fax: 0471-2337148, E-Mail: kshrctvpm@vsnl.net.
Madhya Pradesh The Chairperson Paryavas Bhawan, Arera Hills, Jail Road, Bhopal-462001, STD: 0755, Tele(o):2764505, Fax: 574028, E-Mail: mphrc@sancharnet.in,	**Manipur** The Chairperson Courts complex, Lamphel, Imphal -795004, STD: 0385, Fax: 2410472, E-Mail: mhrc@man.nic.in.
Maharashtra The Chairperson 9, Hajarimal Somani Marg, Near CST Railway Station, Mumbai-400001. Fax: 022-2885858, 22091804. Tele(o):22071155/22073434	**Orissa** The Chairperson Toshali Plaza Complex (2nd Floor), Satya Nagar, P.O. Saheed Nagar, Bhubaneswar-751007, Orissa Fax: +91- 674- 2564333/2390563/2565110 Ph: +91-674- 2572234 (O) 2436634 (R)
Punjab The Chairperson SCO NO. 20-21-22, SECTOR 34A, CHANDIGARH 160 034, India Ph. : 91-172-2608463, 91-172-2608575, 91-172-2608539 Fax : 91-172-2608520 (Chairperson) 91-172-2608469 (Secy.) 91-172-2608587 (I.G) Email: pshrc_chd@yahoo.com Website: www.pshrc.net	**Rajasthan** The Chairperson State Secretariat, Jaipur, Tele(o):): 0141-2227868 Fax: 2227738, E-Mail: rshrc@raj.nic.in. Website: www.rshrc.nic.in
Tamil Nadu The Chairperson Thiruvarangam Maligai, 143, P.S. Kumaraswamy Raja Salai, Greenways Road, Chennai - 600 028. Ph: +91-44-24951484 Fax: +91-44-24951484 E-Mail: shrc@tn.nic.in Website: www.	**Uttar Pradesh** The Chairperson 1/183, Vineet Khand, Gomati Nagar, Lucknow – 226010. Tele(o):0522-2726742 , Fax: 0522-2726743, E-Mail: uphrclko@yahoo.co.in
West Bengal The Chairperson Bhabani Bhavan, Alipore, Kolkata-700027, Tele(o): 033-24797259, Fax: 033-24799633, E-Mail: wbhrc@cal3.vsnl.net.in. Website: www.wbhrc.nic.in	

4. Inter-Governmental Organizations (IGOs)

African Commission on Human and Peoples' Rights Kairaba Avenue, P.O. Box 673 Banjul, The Gambia Tel.: +220 4392 962, Fax.: +220 4390 764 E-mail: achpr@achpr.org , http://www.achpr.org	**European Court of Human Rights** 67075 Strasbourg-Cedex, France Tel.: +33-3-88 41 20 18 Fax: +33-3-88 41 27 30 http://www.echr.coe.int/
European Committee for the Prevention of Torture Human Rights Building, Council of Europe F-67075 Strasbourg Cedex, France Tel.: +33 3 88 41 39 39 Fax: +33 3 88 41 27 72 E-mail: cptdoc@coe.int, www.cpt.coe.int	**Inter-American Commission on Human Rights** 1889 F St., NW, Washington, D.C. USA 20006. Tel.: +1-202-458 6002 Fax: +1-202-458 3992. E-mail: cidhoea@oas.org http://www.cidh.oas.org/
Office of the UN High Commissioner for Human Rights OHCHR-UNOG, CH 1211 Geneva 10, Switzerland, Tel.: +41-22-917 9000 Fax: +41-22-917 9022 E-mail: tb-petitions@ohchr.org http://www.unhchr.ch/	**UN Committee Against Torture** c/o Office of the High Commissioner for Human Rights (above) www.ohchr.org/english/bodies/cat/
UN Special Rapporteur on the Right to the Highest Attainable Standard of Health c/o Office of the High Commissioner for Human Rights (above), Fax: +41 22 917 9003 E-mail for urgent appeals: urgent-action@ohchr.org http://www.ohchr.org/english/issues/health/right/index.htm	**UN Special Rapporteur on Torture** c/o Office of the High Commissioner for Human Rights (above) E-mail for urgent appeals: urgent-action@ohchr.org http://www.ohchr.org/english/issues/torture/rapporteur/index.htm
UN Voluntary Fund for Victims of Torture Secretariat of UN Voluntary Fund for Victims of Torture c/o Office of the High Commissioner for Human Rights Trust Funds Unit/Support Services Branch, CH-1211 Geneva 10, Switzerland Tel.: +41 22 917 93 15, Fax: +41 22 917 90 17 E-mail: unvfvt@ohchr.org www.unhchr.ch/html/menu2/9/vftortur.htm	

5. Non-Governmental Organizations (NGOs) and Professional Associations

Amnesty International (AI) International Secretariat 1 Easton St, London WC1X 0DW UK Tel.: +44 20 7413 5500 Fax: +44 20 7956 1157 E-mail: amnestyis@amnesty.org http://www.amnesty.org/	**Association for the Prevention of Torture (APT)** Route de Ferney 10, Case postale 2267, CH-1211 Geneva 2 Switzerland Tel.: +41-22-919 21 70 Fax: +41-22-919 21 80 E-mail: apt@apt.ch http://www.apt.ch/

British Medical Association BMA House, Tavistock Square London WC1H 9JP, UK Tel.: 020 7387 4499, Fax: 020 7383 6400 E-mail: http://www.bma.org.uk/ap.nsf/Content/Hubcontactus (through web form) http://www.bma.org.uk/ap.nsf/Content/Hubethics	**The Center for Victims of Torture (Minnesota)** Minneapolis Healing Center 717 East River Road Minneapolis, MN 55455 USA Tel.: +1 612.436.4800 Fax: +1 612.436.2600 E-mail: cvt@cvt.org www.cvt.org/main.php
Human Rights Foundation of Turkey Menek□e 2 Sokak No: 16/5, 06440 Kızılay, Ankara Turkey Tel.: +90 312 417 71 80 Fax: +90 312 425 45 52 E-mail: tihv@tr.net www.tihv.org.tr/eindex.html	**Human Rights Watch (HRW)** 350 Fifth Avenue, 34th Floor New York, NY 10118-3299 USA Tel.: +1-212-290 4700 Fax: +1-212-736 1300 E-mail: hrwnyc@hrw.org http://www.hrw.org/
International Committee of the Red Cross 19 Avenue de la Paix CH 1202 Geneva, Switzerland Tel.: +41-22-734 60 01 Fax: +41-22-733 20 57 E-mail: webmaster.gva@icrc.org http://www.icrc.org/	**International Rehabilitation Centre for Torture Victims (IRCT)** Borgergade 13, P.O. Box 9049 DK-1022 Copenhagen K, Denmark, Tel.: +45-33-76 06 00 Fax: +45-33-76 05 00 E-mail: irct@irct.org , http://www.irct.org (includes the contact details of centres for victims of torture in many countries)
Medical Foundation for the Care of Victims of Torture 111 Isledon Road, London N7 7JW, UK Tel.: +44 20 7697 7777 Fax: +44 20 7697 7799 E-mail: through form on website www.torturecare.org.uk	**Physicians for Human Rights (PHR)** Two Arrow Street Suite 301, Cambridge, MA 02138, USA Tel.: +1-617- 695-0041, Fax: +1-617-301-4250 E-mail: phrusa@phrusa.org http://www.phrusa.org/
REDRESS 87 Vauxhall Walk London SE11 5HJ UK Tel.: +44 207 7793 1777 Fax: +44 207 7793 1719 E-mail: info@redress.org http://www.redress.org/	**World Health Organisation** Avenue Appia 20 1211 Geneva 27 Switzerland Tel.: + 41 22 791 21 11 Fax: + 41 22 791 3111 E-mail: info@who.int http://www.who.int/ethics/en/
World Medical Association (WMA) 13 ch. du Levant CIB - Bâtiment A 01210 Ferney-Voltaire, France Tel.: +33 4 50 40 75 75 Fax: +33 4 50 40 59 37 E-mail: wma@wma.net http://www.wma.net/	**World Organisation Against Torture (OMCT)** PO Box 21 8 rue du Vieux-Billard CH-1211 Geneva 8, Switzerland Tel.: + 41 22 809 4939 Fax: + 41 22 809 4929 E-mail: omct@omct.org http://www.omct.org/

EU All State Office Address

Andhara Pradesh Door No: 6-1-69/4/2 Lutheran Church Road, Lakdi-Ka-Pool, Hydrabad-500 004. Ph: +91-866-23230313 E-mail: ap@pwtn.org	**Bihar** L-1/1, Shri Krishna Puri, Patna – 800 001, BIHAR Ph: +91-651-3250115 E-mail: bihar@pwtn.org
Karnataka SICHREM, No.35, Anjanappa Complex, Ground Floor, Hennur Main Road, Lingarajapuram, Bangalore 560 084 Ph : +91-80-25473922, 25463308 Ph & Fax :080-25492856 E-Mail: karnataka@pwtn.org	**Kerala** 3/354, Chirathara, Muttada PO, Trivandrum - 695 025. Ph : +91-471-2465036 E-mail: kerala@pwtn.org
Orissa No.294-A, Sahid Nagar, Bhubaneswar 7, Orissa. Ph : +91-6743-2543318 E-Mail: orissa@pwtn.org	**Rajasthan** Sasvika Sangatan, Sameeksha Campus, Near Pavansuth Colony, Opp. T.T. College, Jaipur Road, Mirshali, Ajmer – 305 001. Ph & Fax : +91-145-2621466, 2424719 E-mail: rajasthan@pwtn.org
Tamil Nadu People's Watch Tamil Nadu, 6 Vallabhai Road, Madurai – 625 002 Ph :0452-2531874, 2539520 Fax: 0452-2531874 E-Mail: tamilnadu@pwtn.org	**Uttar Pradesh** S-6/25-26, Police Line, Bakki Bazar, Varanasi-221 002 Mob:+91-9839452531 E-mail: up@pwtn.org
West Bengal 26 Guitendal Lane, Howrah-711101 West Bengal India. Phone: +91-33-26404520, 26508700 Fax : +91-33-2640 4118 E-mail: masumindia@pwtn.org	

The European Union

The European Union is established in accordance with the Treaty on European Union. There are currently 25 Member States of the Union. It is based on the European Communities and the member states co-operation in the fields of Common Foreign and Security Policy and Justice and Home Affairs. The five main institutions of the European Union are the European Parliament, the Council of Ministers, the European Commission, the Court of Justice and the Court of Auditors.

The European Union is a major player in international co-operation and development aid. It is also the world's largest humanitarian aid donor. Today, the European Community has political and financial responsibility for over 11% of the world's public aid (ODA), compared with 5% in 1985.

The primary aim of the EC's own development policy, agreed in November 2000, is the eradication of poverty. To enhance its impact, the EC is targeting its assistance on six priority areas: trade and development; regional integration and co-operation; support to macroeconomic policies and equitable access to social services; transport; food security and sustainable rural development; institutional capacity building, good governance and the rule of law. In addition to these core areas, important crosscutting issues are being mainstreamed into development activities namely: human rights, gender equality, environment and conflict prevention.

Delegation of the European Commission in India
65 Golf Links, New Delhi 110 003, India
Tel: +91 11 24629237
Email: delegation-india@ec.europa.eu

Friedrich-Naumann-Foundation

The Friedrich Naumann Foundation is a German non-profit institution primarily engaged in the strengthening of democratic and pluralist development both in the industrialized and the developing world. The Naumann Foundation has its activities spread over in more than 60 countries across the world.

The Friedrich Naumann Foundation promotes the principle of freedom in human dignity, both in Germany as well as abroad together with its partners-through political education, political advice and political dialogue. The Foundation has the following objectives:

- To sensitize people on political issues and motivate them to get involved.
- To provide liberal answers to the burning issues of the day, and to incorporate new findings and experiences-including those from other cultures-into liberal solutions.
- To strive for cooperation in development through free international trade and through helping to establish free and responsible civic societies in developing countries.
- To work towards world wide victory of human and civil rights.

India and Regional Office, South Asia
Friedrich-Naumann-Foundation
USO House
6, Special Institutional Area
New Delhi 110067, India
Tel: +91 11 26862064
Email: officeindia@india.fnst.org

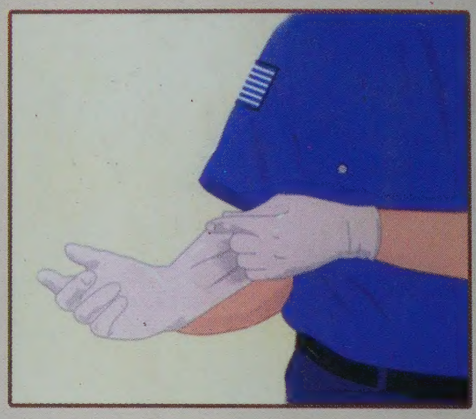
You Can Make A Difference

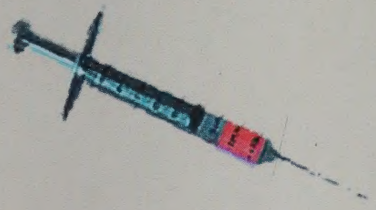
Torture destroys human dignity and denies the Right to Life

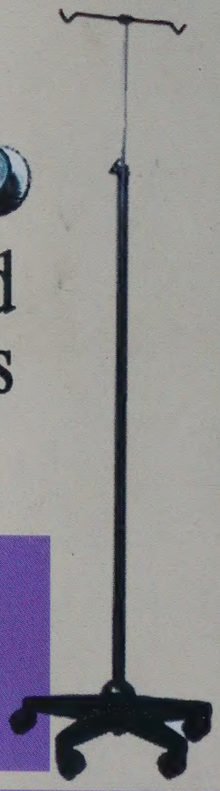
We, Doctors and Hospitals, say "No" to Torture

"The Physician shall not aid or abet torture nor shall be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights."

Code of Medical Ethics, Medical Council of India – Notification dated 6th April 2002







In order to restore shattered lives we need doctors, hospitals, lawyers, academicians and political parties

Above all this, we need people like you to understand the emotions of torture survivors and reach out to their hearts

National Project on Preventing Torture in India

6, Vallabai Road, Madurai-625 002

Ph: +91-452-2531874, 2539520 Fax: +91-452-2531874 E-Mail:no2torture@pwtn.org Website: www.pwtn.org